


S Home health services manual.  
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Department of Public Health  
and Human Services

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## SUBJECT:

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Department of Public Health  
and Human Services

SECTION:

INTRODUCTION

HOME HEALTH SERVICES

SUBJECT:

Manual Program

**OBJECTIVE:** This manual provides policies, procedures, data, information, and instructions covering the Home Health Services Program. This manual replaces all previously issued policy and procedural information relating to the Home Health Services Program.

**MANUAL**

**REVISIONS:** Changes to program policy are transmitted by manual page revisions. Manual revisions are completed by the manual originator quarterly (January, April, July and October). Critical information will be transmitted immediately.

Manual pages contain valuable information for long-term retention and are formally prepared, edited, identified, filed, and indexed. Upon receipt, remove the obsolete manual pages and replace with the new and revised pages.

CONTROL NUMBER--The control number for each manual page is the HH number. For accurate placement, file all documents in numerical sequence (from FRONT to REAR) in the appropriate manual chapter.

**MANUAL**

**MAINTENANCE:** MANUAL HOLDER'S RESPONSIBILITY--The manual holder is responsible for inserting documents and keeping the manual up-to-date. The Contents Index indicates the publication date of each subject listed to assist in auditing the manual contents.

Missing or Superseded Documents--Send requests to:

Community Services Bureau  
Senior & Long Term Care Division  
PO Box 4210  
Helena, MT 59604

## SECTION:

INTRODUCTION

## SUBJECT:

Manual Program

INFORMATION  
RETRIEVAL:

CONTENTS INDEX--This index lists the subjects by number.

Contents Check--To determine whether a particular document is the latest one published, check the date of page 1 of the document against the publication date listed in the Contents Index. At least once a year, check all documents to be certain that the manual is complete and up-to-date.

ALPHA SUBJECT INDEX--This index lists the subjects alphabetically.

REVISION PERIODS--Indexes are updated quarterly to cover all changes, to include all new documents being added, and to remove obsolete data, documents, or forms.

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Department of Public Health  
and Human Services

**SECTION:**

## INTRODUCTION

HOME HEALTH SERVICES

**SUBJECT:**

Clarifying/Interpreting  
Policy or Procedure

If, after consulting this manual, individuals are unable to answer questions or resolve issues that arise in the course of their work, a clarification or interpretation of policy may be requested from the Regional Program Officer (RPO). (Refer to section HH 803 for a list of RPOs.)

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Department of Public Health  
and Human Services

**SECTION:**

PROGRAM DESCRIPTION

HOME HEALTH SERVICES

**SUBJECT:**

Program Goals

PROGRAM GOALS--The goal of the Home Health Services Program is to avoid unnecessary institutionalization or hospitalization by providing skilled nursing or therapy services in the recipient's residence. The program can contain health care costs by providing this service.

The program accomplishes this goal by providing part-time nursing services and restorative therapy services.

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Department of Public Health  
and Human Services

SECTION:

PROGRAM DESCRIPTION

HOME HEALTH SERVICES

SUBJECT:

Legal Authority

LEGAL AUTHORITY--Home health services are a part of the Montana Medicaid program as authorized by Section 1905(1)(18) of the Social Security Act.

Federal regulations governing home health services are in 42 CFR 440.70 and 42 CFR 441.15.

Section 53-6-101 of the Montana Codes Annotated and Sections 37.40.701 through 37.40.705 of the Administrative Rules of Montana (ARM) provide the state legal authority to implement the Home Health Services Program.

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Department of Public Health  
and Human Services

SECTION:

PROGRAM DESCRIPTION

HOME HEALTH SERVICES

SUBJECT:

Federal Requirements

REFERENCE: 42 CFR 440.70 and 42 CFR 441.15

GENERAL PROGRAM  
DESCRIPTION:

FEDERAL REQUIREMENTS--The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), sets forth guidelines for Medicaid programs to obtain federal financial participation (FFP).

SUMMARY--These sections of the CFR define home health services, who can deliver services, service requirements, and recipient eligibility.

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Department of Public Health and Human Services	SECTION: PROGRAM DESCRIPTION
HOME HEALTH SERVICES	SUBJECT: Organizational Responsibilities

ORGANIZATIONAL RESPONSIBILITIES--The Home Health Services Program has multiple levels of agency involvement. The responsibilities of the organizations follow.

- FEDERAL: The U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), is the federal agency responsible for administering the Medicaid Program.
- STATE: The Department of Public Health and Human Services (DPHHS) is the state agency responsible for administering the Medicaid Program.
- DIVISION: The Senior and Long Term Care Division is responsible for developing, implementing, and monitoring policies and procedures for all senior and long term care services, including the Medicaid Home Health Services Program. (Refer to HH 801 for the Division Organizational Chart.)
- REGIONAL PROGRAM OFFICERS: Regional Program Officers (RPOs) are Department employees supervised by the Community Services Bureau of the Division. They are located in DPHHS District Offices around the state. RPOs are primarily responsible for local representation of the Community Services Bureau programs, which include pre-admission screening, personal assistance, home and community based services (HCBS), hospice, home dialysis, and home health services. (Refer to HH 803 for a directory of Regional Program Officers.)

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PROGRAM DESCRIPTION

## SUBJECT:

Organizational Responsibilities

MOUNTAIN PACIFIC  
QUALITY HEALTH  
FOUNDATION:

The Mountain Pacific Quality Health Foundation (Foundation) is a peer review organization that contracts with the Department to perform prior authorization functions of the Home Health Services Program. It is also responsible for the annual review of home health services.

ELIGIBILITY  
STAFF:

Eligibility Staff are Department employees located in County Offices of Human Services who determine financial eligibility for Medicaid. (Refer to HH 809 for a directory of County Offices of Human Services.)

## FISCAL AGENT:

The Department currently contracts with ACS, Inc. to process all Medicaid claims.

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Department of Public Health and Human Services  HOME HEALTH SERVICES	SECTION:  PROGRAM DESCRIPTION
	SUBJECT:  Medicaid Overview

MEDICAID OVERVIEW--The purpose of the Medicaid Program is to provide Medicaid eligible and medically needy persons with ongoing and preventive medical care necessary for maintaining their health and promoting their own self-care. The Medicaid Program was created in 1965 by Congress through Title XIX of the Social Security Act and was implemented in Montana in 1967 through Title 53, Chapter 6 of the Montana Codes Annotated and Section 46.12 of the Administrative Rules of Montana. The Montana Department of Public Health and Human Services is the designated single state agency for administering the Medicaid Program.

FEDERAL REQUIREMENTS--To receive federal funds for the program, the state must follow the federal regulations in 42 CFR, Parts 430 to 460. The regulations provide for two types of Medicaid Programs: mandatory and optional. Mandatory programs must be offered for states to receive federal Medicaid funds. Federal Medicaid funds are available for optional programs if state legislatures authorize the expenditure of state funds.

STATE PLAN--States define the extent and scope of services provided, service standards, and rates of payment to providers. The Department provides these details to HCFA in a State Plan which can be amended at any time. Services available to all Medicaid recipients are called State Plan services.

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Department of Public Health  
and Human Services

## SECTION:

## PROGRAM DESCRIPTION

HOME HEALTH SERVICES

## SUBJECT:

Medicaid Services

Reference: 42 CFR 440.210 and 440.220

MANDATORY SERVICES--Medicaid services required by the federal government include:

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals under age 21. In addition to all available State Plan Medicaid services, children may also receive these services: chemical dependency treatment, chiropractic, dietitian, residential treatment facilities, private duty nursing, respiratory therapy, school-based services, therapeutic group and foster care.
- Family Planning
- Home Health (For individuals age 21 and over, supplies, nursing services, and aide services only.)
- Inpatient Hospital
- Laboratory and X-ray
- Medical and surgical services of a dentist
- Nurse Midwife
- Nurse Practitioner
- Nursing Facility Care
- Outpatient Hospital
- Physician
- Rural Health Clinics (including Federally Qualified Health Centers)

## SECTION:

PROGRAM DESCRIPTION

## SUBJECT:

Medicaid Services

OPTIONAL SERVICES--Medicaid services that Montana has chosen to provide include:

- Ambulatory Surgical Centers
- Audiology/Hearing Aids
- Community Mental Health
- Dental and Denturist Services
- Diagnostic Clinics
- Durable Medical Equipment, Prosthetic Devices, Medical Supplies
- Eyeglasses and Optometric Services
- Freestanding Dialysis Clinics
- Home Dialysis Attendant Care
- Home Infusion Therapy
- Hospice
- Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- Licensed Professional Counselors
- Mid-level Practitioners (Nurse Specialist, Physician Assistant, Advanced Practice Nurse, and Certified Nurse Midwife)
- Personal Assistance
- Podiatry
- Prescribed Drugs
- Psychology
- Speech, Occupational, and Physical Therapy

## SECTION:

PROGRAM DESCRIPTION

## SUBJECT:

Medicaid Services

- Social Work
- Targeted Case Management
- Transportation Services

PROGRAM LIMITATIONS--States have the option to establish limitations on the amount of services available to Medicaid recipients.

Refer to HH 1007 for a summary of Montana's Medicaid services. The summary outlines program scope, limitations, reimbursement, and copayment requirements for all covered services.

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Department of Public Health  
and Human Services

SECTION:

PROGRAM DESCRIPTION

HOME HEALTH SERVICES

SUBJECT:

Relationship of Medicaid and  
Medicare

DESCRIPTION OF MEDICARE--Medicare is a federal health insurance program for persons 65 years of age and older, and certain persons under the age of 65 who are disabled or who have End Stage Renal Disease. Unlike Medicaid, persons do not have to meet an income test to qualify for Medicare. Eligibility is based on the individual's work history under the Social Security or Railroad Retirement systems.

PROGRAM ADMINISTRATION--Medicare, like Medicaid, is a federal program administered by the Health Care Financing Administration (HCFA). Medicare is financed from Social Security taxes and monthly premiums and covers the same services and supplies nationwide.

HOSPITAL INSURANCE (PART A)--Medicare hospital insurance helps pay for medically necessary inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care.

MEDICAL INSURANCE (PART B)--Medicare medical insurance helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, speech pathology services, and a number of other medical services and supplies not covered by hospital insurance. Medical insurance can also help pay for necessary home health services when hospital insurance cannot pay and the recipient doesn't have Part A Medicare.

DEDUCTIBLES AND CO-INSURANCE--Medicare does not pay the full cost of some covered services. As with most private health insurance policies, Medicare has deductibles and co-insurance that must be paid by the insured person. If the Medicare insured person also receives Medicaid, Medicaid may pay some of

## SECTION:

PROGRAM DESCRIPTION

## SUBJECT:

Relationship of Medicaid and Medicare

the deductible and co-insurance costs. Medicaid may also pay for the person's medical insurance premium.

PAYMENT SYSTEM--Medicare payments are handled by private insurance organizations under contract with the federal government. Organizations handling Part A claims are called intermediaries and organizations handling Part B claims are called carriers.

In Montana, the intermediary and carrier is either Blue Cross/Blue Shield or WellMark. Medicare's basis for how the payments will be made is called "assignment". "Assignment" means that the provider bills, receives and accepts the payment as payment in full. "Non-Assignment" means the provider does not accept the payment rate and the client is responsible for the total charges regardless of what Medicare allows. This principle does not apply in Medicaid since Medicaid payment is made only to providers and is payment in full.

FURTHER INFORMATION--For more detailed information about the Medicare Program, contact Blue Cross/Blue Shield.

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Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

**SUBJECT:**

Civil Rights

GENERAL RULE--Title VI and Title IX of the Civil Rights Act require that no person shall, on the grounds of race, color or national origin, creed, sex, religion, political ideas, marital status, age or handicap, be excluded from participating in, be denied benefits, or otherwise be subjected to discrimination under any program receiving federal funding.

Affirmative steps must be taken to employ and advance in employment qualified individuals with disabilities.

COMPLIANCE--All contracts with providers contain a section on civil rights. Providers shall comply with the Civil Rights Act and the Montana Human Rights Act, Title 49, Chapter 2, MCA, as amended and all requirements imposed by or pursuant to the regulation.

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Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

**SUBJECT:**

Fair Hearings

References: ARM 46.2.201 - 46.2.214

REQUIREMENT--Any Medicaid provider or Medicaid recipient may appeal any adverse action which is felt to have affected the amount or scope of Medicaid payments received and/or eligibility for Medicaid.

ADVERSE ACTION--An adverse action means:

- a failure of the department to provide a claimant an opportunity to make application for benefits;
- a failure of the department to act promptly on a claimant's application for benefits;
- an action by the department denying, suspending, reducing or terminating benefits of a claimant;
- an action by the department establishing conditions on the manner or form of benefits, including restrictive or protective payments, or establishing conditions for the receipt of benefits, including a work requirement;
- an action by the department to deny, terminate or fail to renew certification or a provider agreement for the Medicaid program for any skilled nursing facility or intermediate care facility;
- an action by the department to deny, suspend, revoke or terminate or fail to renew certification, licensure or the registration certificate of the provider;
- an action by the department establishing the rate of reimbursement for a medical

## SECTION:

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ADMINISTRATION

## SUBJECT:

Fair Hearings

assistance provider or denying in whole or part a medical assistance provider's claim for services or items; or

- any other department action or determination with respect to which a right to hearing is specifically granted by department rule, but for which a hearing process is not otherwise provided.

REQUESTING FAIR HEARINGS--A provider, recipient, or his/her official representative must request a hearing in writing and mail the request to the Department of Public Health and Human Services, Hearings Officer, P.O. Box 202951, Helena, MT 59620-2951. A provider request must be postmarked or delivered to the Department no later than 30 calendar days following the date of notice of the determination. An applicant or recipient request must be postmarked or delivered no later than 90 calendar days following the date of notice of determination.

CONDUCTING FAIR HEARINGS--Fair Hearings are conducted by the Department's Hearing Officer. Decisions by the Hearing Officer are binding and must conform to federal and state laws, regulation, or policy and must be based exclusively on evidence and other material introduced at the hearing. An administrative review of the action will precede a Fair Hearing. Either the Hearing Officer or the parties requesting the hearing may ask for a pre-hearing conference.

ADMINISTRATIVE REVIEW--The purpose of the administrative review is for the Department to reconsider its proposed action. The requestor of the hearing will review the matter with the Department representative, present additional information to the Department concerning the action, and obtain additional explanations from the Department on the reasons for the action. The Department will inform the indi-

## SECTION:

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ADMINISTRATION

## SUBJECT:

Fair Hearings

vidual of the determination after the administrative review has been completed.

PRE-HEARING CONFERENCE--The purposes of the pre-hearing conference are to consider simplification of the legal and factual issues in preparation for the hearing, obtain admissions of fact and documents, explore the possibility of settlement, establish what evidence and witnesses will be presented, and discuss any other matters that may aid in disposing of the Fair Hearing.

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Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

**SUBJECT:**

Release of Information/  
Confidentiality

REQUIREMENT--Federal law requires that Medicaid information about an applicant/recipient and provider eligibility, or the amount of assistance and services provided is confidential. Under this protection, information regarding recipients cannot be released without their written consent. (Refer to HH 399-1 for an example of a consent form.)

Information released for purposes directly connected with administration of the Medicaid Program does not require recipient consent such as:

1. Establishing eligibility;
2. Determining the amount of medical assistance;
3. Providing services for recipients; and
4. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to Medicaid fraud or abuse.

PROCEDURES--The home health agency should develop procedures to ensure that confidentiality is maintained. These procedures must include at least the following:

1. A determination that the individual requesting information will be using it for purposes directly connected with administration of the Medicaid Program.
2. Documentation of the date, purpose, and requesting individual/agency in the recipient record.

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## SUBJECT:

Release of Information/  
Confidentiality

3. Denial of any request for recipient information unrelated to the administration of the Medicaid Program until a recipient signed and dated release of information is received.

All Department application forms state that the confidential information provided by the recipient will be protected and will only be used for purposes directly related to administration of the program.

FREEDOM OF INFORMATION--Recipients have a right to view their own records.

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Department of Public Health  
and Human Services

## SECTION:

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

## SUBJECT:

Third Party Liability (TPL)

Reference: ARM 37.85.407

REQUIREMENT--According to state and federal law, the state must take all reasonable measures to determine the legal liability of third parties to pay for health care and services covered by Medicaid.

The Medicaid Program is the payor of last resort to other insurance programs. Medicaid does pay before Crime Victim Compensation Funds, Indian Health Services, and Disaster Relief Funds.

If a third party source is known to the provider, the provider must bill the third party before billing Medicaid and indicate any amount received from the third party on the Medicaid claim. Providers must submit a copy of the statement of payment or denial from the resource when billing for any balance.

Examples of third party resources include:

- Medicare
- Veterans' Administration Medical Payment
- Private Insurance
- TRICARE and TRICARE for Life (formally Civilian Health and Medical Program of the Uniformed Services-CHAMPUS)
- Workers' Compensation

Medicaid no longer requires a formal denial Explanation of Medical Benefits (EOMB) notice of noncoverage for those home health recipients who are dually eligible for Medicare and Medicaid. In lieu of a formal

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ADMINISTRATION

## SUBJECT:

Third Party Liability (TPL)

denial of Medicare coverage, Medicaid will allow a self-certification by the provider. The provider will enter by means of a stamp, verbatim, in Field 84 of the UB-92 claim form (REMARKS), the following statement:

FORCE EXC. 261. NONE OF THE SERVICES, EQUIPMENT OR SUPPLIES LISTED ON THIS CLAIM ARE MEDICARE COVERED FOR THIS PATIENT UNDER THIS PLAN OF CARE. \_\_\_\_\_

It is the provider's responsibility to assure this statement is true and accurate. The department may, at any time, request the provider demonstrate that Medicare payment was not available for such services. This may include obtaining an actual Medicare denial.

THIRD PARTY LIABILITY QUESTIONS--Questions about third party policy or claims submission should be directed to the TPL Unit of the Quality Assurance Division or ACS's Provider Relations Section.

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Department of Public Health  
and Human Services

## SECTION:

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

## SUBJECT:

Fraud and Abuse

Reference: ARM 37.85.501 - 37.85.513

REQUIREMENT--The Department is charged by federal and state law with the responsibility of identifying, investigating, and referring to law enforcement officials cases of suspected fraud or abuse of the Medicaid Program by either providers or recipients. Sanctions may be imposed against a Medicaid provider for reasons including but not limited to:

1. Submitting a false or fraudulent claim;
2. Failure to maintain and retain required records;
3. Failure to disclose or make available records to the Department;
4. Failure to provide and maintain the quality of services accepted within medical community standards;
5. Breach of the terms of the provider contract;
6. Submitting a false or fraudulent application for provider status;
7. Rebating or accepting a fee or charge for a Medicaid recipient referral;
8. Charging Medicaid recipients for amounts over and above the amounts paid by Medicaid; and/or
9. Failure to meet federal or state licensure or certification requirements.

REPORTING PROCEDURE--Cases of potential fraud and program abuse should be referred to the Department. All such referrals are held confidential and may be made anonymously. To make a report, call 1-800-376-1115.

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Department of Public Health  
and Human Services

SECTION:

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

SUBJECT:

Surveillance and Utilization  
Review (SURS)

REQUIREMENT--Federal regulations require states to develop and implement statewide surveillance and utilization control programs to promote the most effective and appropriate use of available services. Utilization control must include a post-payment review process for reviewing recipient utilization profiles and provider service profiles to identify and correct misutilization practices. The Department's Surveillance Utilization and Review Unit is responsible for claim surveillance and utilization review.

PROCEDURES--Procedures and mechanisms employed by the Surveillance Utilization and Review Unit include, but are not limited to:

1. Review of recipient profiles of service utilization;
2. Review of provider claims and payment history;
3. Computer-generated listings of duplicate payments, conflicting dates of service, and over utilization;
4. Internal checks on claim pricing, procedures, quantity, duration, deductibles, co-insurance, provider and recipient eligibility;
5. Medical staff review an application of established medical service parameters;
6. Field auditing activities; and
7. Computer-generated comparative analysis by provider type.

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## SUBJECT:

Surveillance and Utilization  
Review (SURS)

EXPLANATION OF MEDICAL BENEFITS (EOMB) PROGRAM--Every month the Department mails an EOMB to randomly selected recipients. The EOMB details services paid in the recipient's behalf during the previous month. The recipient is requested to verify the receipt of the services and return the form. If a recipient contacts the provider about an EOMB, the provider should refer the recipient to the Department's Surveillance Utilization and Review Section.

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Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

**SUBJECT:**

Medicaid Management Informa-  
tion System (MMIS)

DEFINITION--The Medicaid Management Information System (MMIS) is an automated system of claims processing and information retrieval required to be used by State Medicaid Programs. It includes information on Medicaid providers, recipients, and claims. Data regarding the Home Health Services Program include date, type, amount, frequency, and cost of services, recipient identification, and payment category.

USE OF MMIS DATA--The MMIS data on the Home Health Services Program are available for review and reporting on expenditures. MMIS data are also used to produce utilization data and management information about Medicaid recipients and services.

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Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

**SUBJECT:**

Monitoring and Evaluation

COMPLIANCE REVIEWS--The Community Services Bureau of the Department contracts with the Mountain Pacific Quality Health Foundation to conduct a yearly random sample review of home health services. This review is designed to determine compliance with program rules and policies. The process consists of record reviews, interviews with recipients and/or providers, and peer review if determined necessary. (Refer to HH 311 for further information.)

OTHER MONITORING ACTIVITIES--The Department's Surveillance and Utilization Review (SURS) section may request records as needed to investigate complaints or review provider utilization patterns. In addition, the Health Care Financing Administration also conducts assessments to determine compliance with statutory regulations.

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Department of Public Health  
and Human Services,

HOME HEALTH SERVICES

SECTION:

GENERAL PROGRAM ADMINISTRATION

SUBJECT:

Reporting Suspected Abuse and  
Neglect

REQUIREMENT--All employees of an agency participating in the Medicaid Home Health Services program are mandatory reporters of suspected abuse, neglect, or exploitation.

The Montana Elder Abuse Prevention Act requires that all incidents of suspected abuse, neglect, and/or exploitation of elderly or persons with disabilities be reported immediately to Adult Protective Services.

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Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

**SUBJECT:**

Principles of Charting

**PURPOSE**

This section addresses the minimal charting requirements for Medicaid home health.

**MECHANICS OF CHARTING--**

1. All entries must be legible and in ink;
2. Correct errors by drawing a single line through the error, writing the word "error" above it, initialing it, and then writing the correct entry. NEVER erase, draw multiple lines through an error, or use correction fluid;
3. Do not use ditto marks;
4. Each page should have the recipient's name on it;
5. Record the full date of each entry;
6. Each entry must end with the signature or initial of the person making the entry; and
7. Entries should be made in sequence. If it is necessary to make a late entry, indicate the date of the late entry and the date of the occurrence. For example, 07/30/98 charting for 07/28/98.

**RULES OF CHARTING--**

1. Never sign entries for another person;
2. Never chart before an event occurs; and
3. Never chart multiple visits in one note.

## SECTION:

GENERAL PROGRAM  
ADMINISTRATION

## SUBJECT:

Principles of Charting

CHART CONTENTS--

1. Record pertinent observations, psycho-social and physical manifestations, incidents, any unusual occurrences, or abnormal behavior;
2. Chart facts, what is seen, heard, felt, and smelled. Make objective rather than subjective statements and avoid generalizations, vague comments, and opinions. For example (objective statement), Less talkative than yesterday. Taking medications as prescribed. (subjective) Quiet and cooperative;
3. Record approaches to correcting problems identified in the recipient care plan;
4. Record all teaching efforts, including instruction to the recipient's primary caregivers;
5. Record an opening statement when a recipient is admitted and a closing statement when a recipient is discharged from services; and
6. Record the type of contact; e.g., telephone call, home visit, etc., and identify who made the contact.

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Department of Public Health  
and Human Services

**SECTION:**

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

**SUBJECT:**

Quality Assurance Reviews

As required by Legislative Audit, the department conducts an annual random sample review of paid claims to determine compliance with department rules and policies. This review is conducted by a team of review nurses at the Mountain Pacific Quality Health Foundation.

Agencies will be required to provide requested documentation, participate in the review and answer any questions. Failure to do so violates the Montana Medicaid Provider Enrollment Agreement.

If during the review, the Department/Foundation overlooks a policy violation, the agency is still responsible for any future overpayment due to the violation.

The following standards are used to measure compliance with rules and policies.

STANDARD 1 -Service Criteria

Narrative--The provider agency must maintain documentation of the recipient's eligibility based on service criteria.

Intent--The standard is to ensure that recipients receiving services are eligible and the provider understands Medicaid service criteria. It also insures appropriate documentation is present.

STANDARD 2 - MD Orders

Narrative--The provider agency must obtain an order for services from the recipient's attending or PASSPORT physician prior to the initiation of services. A verbal order is followed by the physician's actual signature within 30 days.

## SECTION:

GENERAL PROGRAM  
ADMINISTRATION

## SUBJECT:

Quality Assurance Reviews

Intent--The standard is to ensure that home health services are ordered by the attending/PASSPORT physician prior to the initiation of services, and an appropriate MD signature is obtained.

STANDARD 3 - Plan of care review

Narrative--The MD must review the plan of care at least every two months not to exceed 62 days.

Intent--The standard is to ensure that the MD reviews the plan of care on a routine basis as required by state and federal laws.

STANDARD 4 - Service Delivery

Narrative--The services ordered in the plan of care are consistent with the services provided by the agency as supported by visit documentation.

Intent--The standard is to ensure that the provider agency is following physician orders and providing the appropriate care.

STANDARD 5 - Medical Necessity

Narrative--The services provided were medically necessary and required a licensed professional.

Intent--This standard is to ensure that services meet medical necessity requirements as outlined by state and federal Medicaid laws.

STANDARD 6 - Dually Eligible

Narrative--Services paid by Medicaid for a dually eligible individual are appropriate as the recipient does not meet Medicare criteria or it is a service not payable by Medicare.

Intent--This standard is to ensure that Medicaid is appropriately reimbursing for claims on dually eligible individuals.

## SECTION:

GENERAL PROGRAM  
ADMINISTRATION

## SUBJECT:

Quality Assurance Reviews

STANDARD 7 - Appropriate Billing

Narrative--The provider charged for the appropriate number of qualifying visits during the review period.

Intent--The standard is to ensure that providers bill for appropriate visits only.

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Department of Public Health  
and Human Services

## SECTION:

GENERAL PROGRAM ADMINISTRATION

HOME HEALTH SERVICES

## SUBJECT:

Quarterly Utilization Report

PURPOSE--This report is designed to assist the department in tracking the Medicaid expenditures and mapping utilization patterns. (Refer to HH 905.)

The report is due at the end of the month following the end of the quarter, or as follows:

<u>Report Period</u>	<u>Date Due</u>
Qtr 1: July 1 - September 30	October 20
Qtr 2: October 1 - December 31	January 20
Qtr 3: January 1 - March 31	April 20
Qtr 4: April 1 - June 30	July 20

Failure to complete mandatory reports violates the Montana Medicaid provider enrollment agreement. Any provider failing to meet the imposed deadlines will have all claims suspended until reports are received.

Reports should be mailed to:

Home Health Program  
DPHHS - SLTC  
PO Box 4210  
Helena MT 59604

Or Faxed to 406-444-7743

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## RELEASE OF CONFIDENTIAL INFORMATION

Recipient's Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_ authorize the release of:

_____	medical information
_____	social information
_____	financial information

to \_\_\_\_\_

\_\_\_\_\_

I understand that any information obtained will be kept confidential and will be used only for purposes directly connected with the formation of a Plan of Care and only for the time period I am requesting enrollment in the Home Health Services Program.

\*\*\*\*\*

Signature of recipient or legal representative signing in his/her behalf:

Date: \_\_\_\_\_







Department of Public Health  
and Human Services

## SECTION:

ELIGIBILITY FOR SERVICES

HOME HEALTH SERVICES

## SUBJECT:

Medicaid Eligibility Require-  
ments

MEDICAID ELIGIBILITY--Applicants for Medicaid must meet eligibility criteria for the appropriate assistance program. All persons applying for Medicaid must meet an income and resource test. The eligibility staff in the County Human Services Office is responsible for determining initial and ongoing financial eligibility for Medicaid. Refer all questions related to the eligibility determination process for Medicaid to the appropriate County Human Services Office. (Refer to HH 809 for a list of the county offices.)

Each month the provider agency must verify continued Medicaid eligibility for each recipient. This can be accomplished by viewing the recipient's Medicaid Identification Card, contacting the Eligibility Staff at the County Human Services Office, or utilizing the eligibility response system.

The telephone numbers for the eligibility response system are:

Faxback (800) 714-0075  
Voice Response (800) 714-0060

If the recipient becomes ineligible, Medicaid payment terminates on the effective date of ineligibility. Verification of Medicaid eligibility is solely the responsibility of the provider agency.

ELIGIBILITY  
GROUPS:

FAMILIES ACHIEVING INDEPENDENCE IN MONTANA (FAIM)--All persons who are included in a monthly grant under the FAIM Program.

SUPPLEMENTAL SECURITY INCOME (SSI)--Persons receiving and/or eligible for cash assistance from the federal SSI Program on the basis of age, blindness, or disability. The Social

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Medicaid Eligibility Requirements

Security Administration determines eligibility for the SSI Program.

MEDICALLY NEEDY--Other persons who meet categorical requirements related to FAIM or SSI but are not receiving cash benefits due to having income exceeding Medicaid standards. These persons may be eligible or become eligible when incurred medical expenses reduce their income to the Medically Needy income level. Eligibility for the Medically Needy Program is established monthly.

QUALIFIED MEDICARE BENEFICIARY (OMB)-- Persons who are eligible for Part B Medicare and who are under 200% of the poverty level are eligible to have Medicaid pay their Medicare Part B premium, deductible, and co-insurance amounts.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLIMB)--Persons who are Part B Medicare eligible with income between 100 and 120 percent of the poverty line and have countable resources less than \$4,000 are eligible to have Medicaid pay their Medicare Part B premium.

WAIVER OF DEEMING--Some persons are eligible for Medicaid through a waiver of deeming. Deeming means that the income and resources of a spouse or parents (for persons 18 years of age or younger) are considered as the income and resources of the individual in determining financial eligibility for Medicaid even though they are not actually contributed.

The requirement for deeming is waived when the recipient is eligible for the Home and Community Based Services (HCBS) Program. The waiver of deeming is effective when recipients are enrolled and receive HCBS.

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Department of Public Health and Human Services	SECTION:  ELIGIBILITY FOR SERVICES
HOME HEALTH SERVICES	SUBJECT:  Home Health Services Eligibility Requirements

INDIVIDUALS TO BE SERVED--To be eligible for Home Health Services, a person must meet all the following criteria:

1. Be Medicaid eligible;
2. Meet service criteria, or cannot reasonably obtain medical services except through a home health agency;
3. Require acute skilled nursing or therapy services on a part-time, intermittent basis to postpone or prevent institutionalization; and
4. Not reside in a hospital, nursing facility, or ICF-MR.

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Department of Public Health and Human Services	SECTION:  ELIGIBILITY FOR SERVICES
HOME HEALTH SERVICES	SUBJECT:  Dually Eligible Individuals

DUALLY ELIGIBLE--An individual dually eligible for Medicare and Medicaid may receive Medicaid home health services if the following are true and documented in the recipient's chart:

1. Medicare coverage is not available; and
2. The individual meets Medicaid eligibility criteria.

Medicaid, as required by Federal law, must demonstrate that other means of reimbursement are not available prior to providing payment. In other words, Medicaid is the payor of last resort, except for Indian Health Services, Disaster Relief and the Crime Victims Compensation fund. The state has the responsibility to insure that this happens.

Under the Interim Payment system, Medicare has set a per recipient cap on the aggregate. A Medicare eligible individual may not be turned down for services because the course of their care (i.e. the cost) will exceed the per beneficiary cap, and they may not be discharged from Medicare when they "hit" the per beneficiary cap. For dually eligible individuals, Medicaid will not become the payor in these situations.

An individual who is dually eligible and meets Medicare home health criteria, **MUST** be admitted to the Medicare benefit. An agency can not circumvent the Medicare limits, by switching the payor source. A dually eligible individual can be admitted to the Medicaid benefit if they do not meet criteria for the Medicare benefit and meet Medicaid criteria.

**NOTE:** When providing services to dually eligible individuals, if the individual's condition changes, re-evaluate the payor source.

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Department of Public Health  
and Human Services

SECTION:

ELIGIBILITY FOR SERVICES

HOME HEALTH SERVICES

SUBJECT:

Service Criteria

DEFINITION--A recipient is considered eligible for home health services if:

1. the recipient's home is the most appropriate location for services based on medical reasons; and
2. the recipient cannot readily obtain medical services except through a home health agency (For example, lack of alternative services.); or
3. there is no equally effective, less costly treatment.

Service criteria must be documented by the agency. This includes appropriate documentation detailing the lack of alternative services. Medicaid will not reimburse for services when this documentation is missing or incomplete.

Children are not eligible solely based upon their age. They must meet the service criteria to receive services. It is inappropriate to provide home health services only as a convenience to parents. Before initiating home health services, private duty nursing services for children **must** be considered (See HH 710).

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Department of Public Health  
and Human Services

SECTION:

ELIGIBILITY FOR SERVICES

HOME HEALTH SERVICES

SUBJECT:

Recipient Identification

GENERAL RULE--Each recipient eligible for Medicaid is assigned a unique Medicaid identification number which is normally their Social Security number. Newborns are assigned a temporary ID number until a Social Security number is available.

MEDICAID IDENTIFICATION CARD--Each month the Department issues an identification card or a letter to each recipient determined to be eligible for Medicaid benefits. The identification card covers eligibility for only one month, so it is important for providers to check the card to be sure it covers the current month. (Refer to HH 1005 for an example of the Medicaid Identification Card.)

PASSPORT TO HEALTH--PASSPORT is a managed care program for Medicaid recipients. It is based on the primary care case management model of managed care. In this model, the recipient chooses a PASSPORT primary physician who acts as a "gatekeeper" for certain services, including home health. The recipient must have home health services authorized by the PASSPORT provider to be eligible for Medicaid reimbursement. Check the recipient's Medicaid card to determine if they are a PASSPORT recipient. For additional information regarding the PASSPORT program, see section XI of the General Medicaid Provider Handbook.

ELIGIBILITY INFORMATION--The County Office of Human Service determines Medicaid eligibility and should be contacted if there is a question about a person's Medicaid eligibility. (Refer to HH 809 for a list of County Offices of Human Services.) Many of the county offices require eligibility inquiries to be submitted

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Recipient Identification

in writing. For those counties, inquiries should be made on the DPHHS-FA-456, "Provider Inquiry of Medicaid Eligibility." (Refer to HH 1008.) These forms are available from Consultec. Eligibility may also be verified through Consultec using Voice Response 800-714-0060 or FAXBACK 800-714-0075.

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Department of Public Health  
and Human Services

SECTION:

ELIGIBILITY FOR SERVICES

HOME HEALTH SERVICES

SUBJECT:

Restricted Card Program

PROGRAM DESCRIPTION--When utilization of Medicaid services is excessive, inappropriate, or fraudulent, recipients are restricted (locked-in) to designated providers and/or required to obtain Department approval before receiving nonemergency services. The most commonly restricted services are physician, pharmacy, and dental.

IDENTIFICATION CARD--The Department issues special Medicaid Identification Cards that identify restricted recipients. Recipients and providers have joint responsibility for exchanging information contained on the restricted card. Information on lock-in requirements specific to a recipient may be obtained from the local County Office of Human Services.

PROVIDER LOCK-IN--When a restricted recipient is locked-in to designated primary providers, Medicaid payment for nonemergency services will be made only to the providers listed on the restricted card (Refer to HH 1006). All other providers, including hospitals, risk being denied Medicaid payment unless the primary provider made a referral or services were for a bona fide emergency. Restricted recipients are responsible for payment of unauthorized services.

PRIOR AUTHORIZATION--Some restricted recipients need nonemergency Medicaid services authorized by the Department before receiving services. In these cases, providers must call the Surveillance/Utilization Review Unit to assure Medicaid payment for nonemergency medical or drug services.

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Department of Public Health  
and Human Services

**SECTION:**

ELIGIBILITY FOR SERVICES

HOME HEALTH SERVICES

**SUBJECT:**

Copayments

**Reference:**

ARM 46.12.204

GENERAL RULE--The federal government allows states to require certain recipients to share Medicaid costs by imposing copayments. A provider cannot deny services to an eligible recipient solely because the recipient cannot pay the copayment.

COPAYMENT REQUIREMENTS--On September 1, 1983, Montana implemented copayments on selected service areas. Copayments apply to both categorically and medically needy recipients. (Refer to HH 1005 for a list of services requiring copayment.)

COPAYMENT EXEMPTIONS--The following Medicaid recipients are exempt from all copayments:

- Individuals under 21 years of age;
- Pregnant women;
- Inpatients in a medical institution who are required to spend a portion of their income on the cost of care (e.g., persons in nursing facilities);
- Individuals receiving emergency or family planning services; and
- Individuals receiving hospice services.

COPAYMENT LIMITS--The total copayment for each Medicaid recipient shall not exceed 5% of the maximum yearly FAIM grant for one adult. The maximum shall be based on the FAIM grant in effect at the end of the state fiscal year.

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Copayments

HOME HEALTH COPAYMENTS--the following are the current copayment amounts:

- \$2.00 per home health aide, nursing, or therapy visit; and
- \$.50 per claim line of supplies.

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Department of Public Health  
and Human Services

SECTION:

ELIGIBILITY FOR SERVICES

HOME HEALTH SERVICES

SUBJECT:

Freedom of Choice

FREEDOM OF CHOICE OF PROVIDERS--Individuals  
have the right to choose among any willing and  
qualified home health providers.

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Department of Public Health  
and Human Services

SECTION:

ELIGIBILITY FOR SERVICES

HOME HEALTH SERVICES

SUBJECT:

Private Pay

GENERAL RULE--Home Health Services are available to persons who choose to pay privately for the services. These persons are not Medicaid eligible.

PROCEDURES--The home health agency develops its own policies and procedures for serving private pay individuals.

FEE SCHEDULE--Fees for private pay persons are established by the home health agency. Private pay fees must not be less than what Medicaid reimburses for the same service.

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Department of Public Health  
and Human Services

SECTION:

ELIGIBILITY FOR SERVICES

HOME HEALTH SERVICES

SUBJECT:

Initial and Prior Authorizations  
for Extended Services

INITIAL AUTHORIZATION--Initial authorization means approval to provide home health services up to program limits.

PROCEDURE--All requests for initial authorization must be made on the Request for Initial Authorization form (DPHHS-SLTC-124). (Refer to HH 902.) This authorization is delegated to the Mountain Pacific Quality Health Foundation. Upon receiving the request, Foundation personnel will approve when appropriate and enter authorization into the MMIS system. The system will generate a prior authorization number. This number will be reported to the provider via an ACS prior authorization notice. Any denied requests will be faxed back to the provider and the Foundation personnel will note the reason.

The provider has five (5) days to request initial authorization.

PRIOR AUTHORIZATION--Approval to extend limits or receive services before they are rendered. The Department does not and will not backdate authorizations. The following home health services require prior authorization:

Home Health Aide Services--All requests for home health aide services must be made directly to the Mountain Pacific Quality Health Foundation. The Foundation will only authorize these services when extenuating circumstances are present. A majority of tasks provided by a home health aide can be accomplished through the Medicaid Personal Assistance Program. This option needs to be exhausted before requesting a home health aide.

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Initial and Prior Authorizations  
for Extended Services

Extended Skilled Nursing Visits-- Prior authorization for extended services is required to provide more than 75 visits in a state fiscal year, July 1 through June 30. Agencies must contact the Foundation to obtain authorization prior to the 75th visit. The agency is responsible for providing appropriate information for the Foundation to make an informed decision regarding the need for this care. All providers must insure the Department there is no other reasonable, equally effective, less costly means to achieve this care.

If an equally effective, less costly service becomes available after prior authorization to exceed the limit is granted, the provider MUST transition the recipient to this service as soon as possible.

If a provider receives approval for an extension of the limit and subsequently needs to exceed the new limit, a new request must be made.

Example: 75 visits provided, 25 additional granted for a total of 100 visits. If additional visits past 100 are needed, a new prior authorization is required.

Extended Therapy Services--Prior authorization is required to provide more than 100 therapy visits in total in the state fiscal year, July 1 through June 30. This is a combined total representing all physical, speech, and occupational therapy provided. Agencies must contact the Foundation to obtain authorization before the 100th visit. Agencies must assure the Foundation that the therapy is restorative, not maintenance.

## SECTION:

ELIGIBILITY FOR SERVICES

## SUBJECT:

Initial and Prior Authorizations  
for Extended Services

PROCEDURE--All requests for prior authorization of extended services must be made on the Request for Prior Authorization for Extended Services form, DPHHS-SLTC-125. (Refer to HH 906.) Authorization for provision of extended services is delegated to the Foundation. The home health agency must fax the DPHHS-SLTC-125 to the Foundation. If Foundation personnel concur, they will sign and fax the request to the home health agency. If the Foundation personnel do not concur, the reasons for nonconcurrency will be documented on the Request for Prior Authorization for Extended Services.

MOUNTAIN PACIFIC QUALITY HEALTH FOUNDATION  
ADDRESS AND PHONE NUMBERS

Mountain Pacific Quality Health Foundation  
3404 Cooney Drive  
Helena, MT 59602

Phone: 1-800-219-7035      443-0320  
Fax: 1-800-413-3890      443-4585

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Department of Public Health and Human Services	SECTION: SERVICE REQUIREMENTS
HOME HEALTH SERVICES	SUBJECT: Referral Process

The home health agency may accept referrals for home health services from any source, but the recipient's primary physician must order such services before implementation. The physician's verbal order for services must be received, documented, and dated in the recipient's chart by agency personnel before the first visit.

If the individual being referred for home health services is not currently eligible for Medicaid, the provider agency will refer the individual to the county eligibility staff to establish Medicaid eligibility. (Refer to HH 809 for a list of county offices.)

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Department of Public Health and Human Services	SECTION: ELIGIBILITY FOR SERVICES
HOME HEALTH SERVICES	SUBJECT: Termination

PROGRAM TERMINATION--Consumer participation in the program terminates when:

1. The consumer no longer has a medical need for services including;
  - a. the recipient no longer meets service criteria; or
  - b. an equally effective less costly alternative becomes available.
2. The consumer requests services to terminate.

PROVIDER TERMINATION--The provider agency may discharge a consumer for other reasons. This is an action of the provider not the Department. When doing this, the provider agency must provide advance notice to the consumer based on provider established policy.

In all cases, the provider agency should make a reasonable effort to ensure continuity and appropriateness of care through referrals to other providers, e.g., other home health agencies, other personal assistance providers, health department, physician, etc.

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Department of Public Health  
and Human Services

## SECTION:

ELIGIBLE SERVICES

HOME HEALTH SERVICES

## SUBJECT:

Service Requirements

General Service Requirements are as follows:

Home health services are provided by a licensed and certified home health agency to a recipient in his/her place of residence to postpone or prevent institutionalization. Services include:

- skilled nursing services;
- home health aide services;
- physical therapy services;
- occupational therapy services;
- speech therapy services; and
- medical supplies suitable for use in the home.

All home health services must be prescribed by the recipient's attending/PASSPORT physician and be part of a written plan of care. The plan of care must be reviewed and renewed by the ordering physician once every two months not to exceed 62 days.

A recipient is considered eligible for home health services when:

1. the recipient's home is the most appropriate location for services based on medical reasons; and
2. the recipient cannot readily obtain needed medical services except through a home health agency; or
3. there is no equally effective, less costly service available.

## SECTION:

ELIGIBLE SERVICES

## SUBJECT:

Service Requirements

Service criteria must be documented by the home health agency on the plan of care. (Refer to HH 404.)

Children are not eligible solely based upon their age. They must meet the service criteria to receive services. It is inappropriate to provide home health services only as a convenience to parents. Before initiating home health services, private duty nursing services for children **must** be considered (See HH 710).

A visit is a personal contact with the recipient in his/her residence to provide a covered home health service. Place of residence includes a recipient's own home, a personal care facility, a foster home, a group home, a rooming house, or a retirement home. Place of residence DOES NOT include a hospital, nursing facility including an ICF/MR, schools, adult day treatment centers, day care centers (child or adult), and day treatment programs for the developmentally disabled.

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Department of Public Health  
and Human Services

HOME HEALTH SERVICES

SECTION:

ELIGIBLE SERVICES

SUBJECT:

Service Limitations and  
Exclusions

HOME HEALTH VISITS--Home health visits have the following limits per state fiscal year (July 1 to June 30):

- |    |                         |     |
|----|-------------------------|-----|
| 1. | Therapies, all combined | 100 |
| 2. | Skilled nursing         | 75  |

Initial Authorization for services must be obtained. Authorization for additional visits beyond the limits may be provided by the Mountain Pacific Quality Health Foundation (Foundation). (Refer to HH 410.)

HOME HEALTH AIDE VISIT--Home health aide services **MUST** be authorized prior to delivery of service. The service is limited to the number of visits granted through the prior authorization period. Home health aide visits are not available when services through the personal assistance program are available. The Foundation is responsible for prior authorization of home health aide visits. (Refer to HH 410.)

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Department of Public Health  
and Human Services

## SECTION:

ELIGIBLE SERVICES

HOME HEALTH SERVICES

## SUBJECT:

Admissions Requirements/  
MD Orders

All recipients must meet eligibility requirements before being admitted to home health services. Each recipient must have a plan of care (HCFA 485) that has been approved by the recipient's physician before the start of services. If the ordering physician is not the individual's PASSPORT physician, in order to bill for services, approval from the PASSPORT physician must be obtained.

A physician's verbal order for services must be received, documented, and dated in the recipient's chart by agency personnel before the first visit. A verbal order must be followed by an actual signature within 30 days.

The HCFA 485 must contain bona fide information regarding the recipient's condition, his/ her eligibility status, and discharge goals.

The provider agency is responsible for insuring Medicaid eligibility before service delivery.  
(Refer to HH 401.)

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Department of Public Health  
and Human Services

SECTION:

ELIGIBLE SERVICES

HOME HEALTH SERVICES

SUBJECT:

Skilled Nursing Services

DEFINITION--Skilled nursing services means nursing services, as defined in the Montana Nurse Practice Act, provided on a part-time basis to meet the medical needs of an eligible recipient. Services that can be delivered by a paraprofessional or nonlicensed individual do not qualify as skilled nursing services, even if a licensed nurse performs the tasks.

SERVICE REQUIREMENTS--Skilled nursing services must be provided by a licensed registered or practical nurse in accordance to the plan of care approved by the recipient's attending physician.

Visits by a Registered Nurse to the home of a Medicaid recipient solely for the purpose of supervising a Licensed Practical Nurse or Nurse's Aide or evaluating the recipient's home health needs will not be reimbursed by Medicaid. These services are considered administrative and are not billable.

Visits by a nurse to the home of a Medicaid recipient solely for the purpose to provide case management services will not be reimbursed by Medicaid. This is not a covered benefit.

Visits by a nurse to the home of a Medicaid recipient solely for the purpose to provide supervision of other non-home health services will not be reimbursed by Medicaid. Other home services have the appropriate mechanisms to supervise their services.

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Department of Public Health  
and Human Services

## SECTION:

ELIGIBLE SERVICES

HOME HEALTH SERVICES

## SUBJECT:

Therapy Services

DEFINITION--Therapy services mean speech therapy, occupational therapy, and physical therapy provided by a licensed therapist through a licensed and certified home health agency.

Speech Therapy Services--means the practice of speech-language pathology as defined in 37-15-102, MCA.

Occupational Therapy Services--means occupational therapy services as defined in 37-15-103, MCA.

Physical Therapy Services--means physical therapy services as defined in 37-15-101, MCA.

Licensed Therapist--means a speech-language pathologist, an occupational therapist, or a physical therapist licensed under the applicable provisions of Title 37, MCA to practice the particular category of service but does exclude an assistant, an aide, or other person whose authority to perform services is restricted to working under the supervision of another.

All therapy services under the home health benefit MUST be provided by a licensed therapist. Services of a therapy assistant, therapy aide, or other person are not reimbursable under home health.

The home health benefit provides coverage for restorative therapy services when the particular restorative therapy services are reasonable and necessary to the recipient's condition. In addition, the recipient is unable to obtain such services through an outpatient clinic or private practice setting due to their medical status. The amount and frequency of services provided must be within

## SECTION:

ELIGIBLE SERVICES

## SUBJECT:

Therapy Services

the particular therapy's generally accepted practice.

For home health services, restorative therapy is defined as follows:

Therapy services that are performed with a reasonable expectation that the recipient's function will improve significantly in a reasonable and predictable period of time, based upon an assessment of the recipient's restoration potential made by a physician in consultation with the licensed therapist. Therapy services are not restorative if the recipient's expected restoration potential would be insignificant in relation to the extent and duration of services required. Therapy services are no longer restorative if at any time after beginning treatment, it is determined that the reasonable expectation of significant improvement will not materialize.

The home health benefit does not cover maintenance therapy services, defined as follows:

Maintenance therapy means repetitive therapy services that are required to maintain functions that are performed without reasonable expectation of significant progress and that do not involve complex and sophisticated therapy services requiring the judgment or skill of a licensed therapist.

The establishment of a maintenance therapy plan by a licensed therapist is reimbursable. The establishment of a maintenance plan includes:

1. the initial evaluation of the recipient;
2. development of a plan that incorporates the treatment objectives of the prescribing physician and is appropriate for the recipient's capacity and tolerance; and

## SECTION:

ELIGIBLE SERVICES

## SUBJECT:

Therapy Services

3. instruction of others in carrying out the plan and further evaluations by a licensed therapist as required.

On occasion, a recipient may require a therapy evaluation as part of obtaining a piece of durable medical equipment. This one time evaluation is reimbursable if there is no other reasonable alternative to obtaining this service. It is expected that the provider agency will explore other alternatives before utilizing home health services in this manner. The provider is still responsible for developing a plan of care, obtaining physician orders, and following all other applicable rules.

Therapy services are limited to a combined maximum of 100 visits per state fiscal year (July 1-June 30). In the event that the recipient may require additional visits, a request for prior authorization must be made. Any service provided after the 100th visit and before the completion of the prior authorization is not reimbursable.

The provider agency is responsible for educating contracted therapy professionals regarding general service requirements and limits under the home health program.

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Department of Public Health  
and Human Services

**SECTION:**

ELIGIBLE SERVICES

HOME HEALTH SERVICES

**SUBJECT:**

Home Health Aide Services

DEFINITION--Home health aide services include assistance with activities of daily living and the care of the household to maintain the recipient in his/her home for a short, definite period of time.

SERVICE REQUIREMENTS--Home health aide services must be provided under the supervision of a registered nurse and in accordance with a written plan of care prescribed by the recipient's attending physician. All home health aide services **MUST** be prior authorized. (Refer to HH 410.)

A recipient receiving or eligible for personal assistance services may not receive home health aide services under Medicaid. The provider may request home health aide services if there exists a bona fide reason why personal assistance services may not be available or appropriate.

Visits of an RN to the home of a Medicaid recipient solely for the purpose of supervising a home health aide are not reimbursable by Medicaid.

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Department of Public Health  
and Human Services

## SECTION:

ELIGIBLE SERVICES

HOME HEALTH SERVICES

## SUBJECT:

Medical Supplies

The home health benefit provides reimbursement of some medical supplies. All medical supplies must:

1. have a therapeutic or diagnostic use;
2. be ordered by the recipient's physician as part of a prescribed treatment; and
3. be essential for agency personnel to follow the plan of care.

The home health benefit excludes any item that can be classified as durable medical equipment (DME). Payment for such items may be available under the DME program. (Refer to HH 508 for a description of this program.)

### Nonroutine Supplies

The physician must order all nonroutine supplies. If not specifically ordered by the physician, the supplies must be necessary to perform services ordered by the physician. Non-routine (billable) supplies are identified by the following conditions:

1. the item follows a consistent charging practice for Medicaid and non-Medicaid recipients receiving the item;
2. the item is directly identifiable to an individual recipient; and
3. the item is furnished at the direction of the recipient's physician and specifically identified in the plan of care.

Limited amounts of medical supplies may remain in the home between visits when repeated applications of a treatment are required and documented as being performed by other care givers. These items must be part of the plan of care. In post payment review, Medicaid will deny the supplies if there is no documentation of their use by the recipient or family.

## SECTION:

ELIGIBLE SERVICES

## SUBJECT:

Medical Supplies

Nonroutine supplies include but are not limited to:

*Catheter Supplies*

- Catheters (all types)
- Catheter plugs
- Catheter trays
- Urinary drainage bags
- Irrigation solutions
- Sterile leg bags

*Dressing Changes and Wound Care*

- adhesives
- cotton-tipped applicators, sterile
- gauze, flats
- drapes, sterile
- eyepads
- gauze, fine mesh
- stockinette dressings
- gauze, idoform
- gauze, kling
- suture/staple removal sets
- gauze, vaseline
- gauze, sponges
- gauze,, sterile
- gauze, stretch
- gloves, sterile
- dressing not containing prescription medications
- nonprescription antibiotic ointment
- tape, adhesive
- tape, hypoallergenic
- tape, twill
- telfa
- wound irrigation and cleaning supplies

*Enteral, Parental and Venipuncture Supplies:*

- needles
- syringes
- feeding tube
- gavage bags
- bulb/piston syringe
- IV tubing
- IV solution (without medication)
- Heparin flush
- vacutainer
- vacutainer needles

## SECTION:

ELIGIBLE SERVICES

## SUBJECT:

Medical Supplies

*Miscellaneous:*

- tracheostomy care trays
- ostomy supplies and dressing changes
- elastic bandages

Routine Supplies

Routine supplies (nonbillable) are customarily used during the course of most home care visits and are usually part of the staff's supplies and not designated for a particular recipient. These supplies are included in the rate per visit of home health services. Routine supplies would not include those ordered by the physician or are essential to home health personnel to effectively carry out the plan of care.

There are conditions when supplies, normally considered routine, are required in quantity, for recurring need and are included in the plan of care. These supplies would be considered non-routine and would be considered billable. Examples include, but are not limited to, tape and 4x4's for major dressings.

## Routine supplies include:

- swabs, alcohol preps, and skin prep pads
- nonsterile applicators
- 4x4's
- gowns
- tape removal pads
- cotton balls
- adhesive paper and tape
- aprons
- masks
- specimen containers
- thermometers
- tongue depressors

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Department of Public Health  
and Human Services

SECTION:

ELIGIBLE SERVICES

HOME HEALTH SERVICES

SUBJECT:

Durable Medical Equipment

Reimbursement for durable medical equipment (DME), prosthetic devices, supplies, including oxygen and oxygen equipment is not available under the home health benefit. Reimbursement for such items may be available under the DME program. The following information is provided for explaining the basic provisions of the DME program.

The DME program defines durable medical equipment as: medical equipment that withstands repeated use; is appropriate in a recipient's residence; is primarily and customarily used to serve a medical purpose; and is generally not useful to a person without illness or injury. This includes common items such as wheelchairs, walkers, canes, commodes, bath equipment, TENS, hospital beds, augmentative communication devices, and more.

Prosthetic devices are defined as replacement, corrective, or supportive devices or appliances that artificially replace a missing portion of the body to: prevent or correct physical deformity or malfunction; or support a weak or deformed portion of the body. This includes common items such as orthotic devices, prosthetic devices, breast prostheses, elastic supports, trusses, prosthetic socks, and prosthetic eyes.

Supplies that are not covered as a portion of the home health benefit may be covered under this benefit. Medical supplies are defined as disposable or nonreusable medical supplies, including, but not limited to, bandages, incontinence supplies, ostomy supplies, oxygen, and oxygen supplies.

## SECTION:

ELIGIBLE SERVICES

## SUBJECT:

Durable Medical Equipment

To obtain these items for a home health recipient, coordinate with a DME provider. Specific items require authorization PRIOR to providing the recipient with the item. These include:

- Air Fluidized Beds, Alternating Pressure Mattress
- Augmentative Communication Devices
- Purchase of hospital bed
- Purchase of wheelchairs
- All items with a cost of \$1,000.00 per line item
- Other items noted in the DME handbook.

The DME program does NOT cover items of convenience or comfort.

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Department of Public Health  
and Human Services

SECTION:

PROVISION OF SERVICES

HOME HEALTH SERVICES

SUBJECT:

Provider Eligibility

PROVIDER REQUIREMENTS--Providers of Home Health  
Services must be:

1. Licensed by the State of Montana;
2. Certified by Medicare; and
3. Enrolled as a Medicaid provider.

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Department of Public Health  
and Human Services

SECTION:

PROVISION OF SERVICES

HOME HEALTH SERVICES

SUBJECT:

Provider Responsibilities

GENERAL RULE--All providers of Home Health Services have the following responsibilities:

1. To retain medical records which fully disclose the extent and nature of services provided to recipients and which support fees charged or payments made;
2. To keep, establish, and maintain accounting records that accurately identify, classify, and summarize all funds and monies received and disbursed, and provide an adequate audit trail;
3. To accept Medicaid payment as payment in full and never charge a recipient additional money unless it is to meet copayment requirements (Refer to HH 407 for a discussion of copayment);
4. To ensure the confidentiality of recipient records and other information related to recipients;
5. To make Medicaid records available for audit by authorized state and federal staff; and
6. To retain medical and financial records, supporting documents, and all other records supporting services provided for six years and three months. If any litigation, claim, or audit is started before the end of the six-year and three-month period, records must be retained until all litigation, claims, or audit findings are resolved.

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Department of Public Health  
and Human Services

SECTION:

PROVISION OF SERVICES

HOME HEALTH SERVICES

SUBJECT:

Provider Enrollment

REQUIREMENT--All providers of Home Health Services must be enrolled in Montana's Medicaid Program.

PROVIDER ENROLLMENT PROCEDURES--All requests for enrollment in the Medicaid Program must be made to Consultec. Enrollment forms can be requested in writing or by calling:

Consultec, Inc.  
P.O. Box 8000  
Helena, MT 59604  
1-800-624-3958 (In-State)  
406-442-1837

PROVIDER ENROLLMENT FORMS--The enrollment form must be completed in its entirety before the enrollment application can be processed by Consultec. The application must include a copy of the current license and HCFA letter granting Medicare approval.

STATUS CHANGES--All status changes such as change in ownership, address, licensure, etc., must be immediately reported in writing to Consultec.

PROVIDER BILLING MANUAL--Consultec furnishes all providers with a Provider Manual upon enrollment. The Provider Manual describes policy and procedures relating to billing for Medicaid services.

PROVIDER POLICY MANUAL--The Community Services Bureau furnishes all providers with a Provider Policy Manual upon enrollment. The policy manual details eligibility, service, administrative and billing requirements. It is updated four times per year. Upkeep is the responsibility of the provider.

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Department of Public Health  
and Human Services

## SECTION:

PROVISION OF SERVICE

HOME HEALTH SERVICES

## SUBJECT:

Payment Requirements

PAYMENT FOR SERVICES--Payment for Home Health Services is contingent on the following factors:

1. The recipient is eligible for Medicaid on the days services are rendered;
2. The provider is eligible for Medicaid participation on the days service is rendered and has agreed to accept the recipient and bill Medicaid;
3. The service is covered by Medicaid;
4. Initial authorization for services has been received;
5. The recipient has not exceeded the limitations for a specific service without proper prior authorization;
6. A third party source has not already paid in full for the service;
7. Services are prescribed in the recipient's plan of care;
8. Services are approved by the PASSPORT provider, when necessary;
9. A clean claim is received by Consultec within 365 days of the dates of service; and
10. Payment is not available for any days a recipient is hospitalized or in a nursing facility. (Payment is available on the date of admission and the date of discharge if the recipient receives and is eligible for a home health service.)

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Department of Public Health  
and Human Services

**SECTION:**

PROVISION OF SERVICE

HOME HEALTH SERVICES

**SUBJECT:**

Payment Processing

REQUIREMENT--Payment for Home Health Services must be made directly to the provider of service. No payment may be made to the recipient or any entity other than the provider of services unless otherwise specified by the Department.

CLAIM FORM--The provider requests payment from Medicaid by submitting a UB-92 Claim Form to Consultec. Providers must purchase their own supplies of the UB-92 Claim Form. Most claims may be transmitted electronically. A claim which includes the stamp described in HH 304 may not be submitted electronically.

PAYMENT DEADLINES--To be reimbursed by Medicaid, providers' clean claims must be received by Consultec no later than 365 days from the date services were provided. A clean claim is one that can be processed for payment without correction, additional information or documentation from the provider

QUESTIONS ON CLAIMS--Questions about the filing of claims or payments should be referred to :

Provider Relations Department  
Consultec, Inc.  
P.O. Box 8000  
Helena, MT 59604.

The in-state toll free number is 800-624-3958.  
The local number is 406-442-1837.

FURTHER INFORMATION--The Montana Medicaid General Provider Handbook is available through Consultec. This handbook addresses issues regarding claims processing and eligibility.

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Department of Public Health  
and Human Services

## SECTION:

PROVISION OF SERVICES

HOME HEALTH SERVICES

## SUBJECT:

Reimbursement Methodology

GENERAL REQUIREMENT--Reimbursement for Home Health Services not paid through other federal, state, or locally funded programs shall be the lowest of the following:

1. The provider's usual and customary (billed) charges; or
2. The rate of reimbursement established by the Department.

METHODOLOGY--Current rates for home health services were established in July 1997 as the average of 60% of the Medicare upper limit for each provider. This rate has been indexed forward each year based upon the provider rate increase granted by the Montana State Legislature.

REVENUE CODES AND RATES--Services provided by a home health agency are reimbursed at the following rates:

Revenue Code	Service	FY02	FY01	FY00	FY99
421	Physical Therapy	63.50	62.56	61.95	61.34
431	Occupational Therapy	63.50	62.56	61.95	61.34
441	Speech Therapy	63.50	62.56	61.95	61.34
551	Skilled Nursing	63.50	62.56	61.95	61.34
571	Home Health Aide	28.35	27.93	27.66	27.39
270	Supplies	90% of charges			

FY99 - 7/1/98 to 6/30/99  
FY00 - 7/1/99 to 6/30/00  
FY01 - 7/1/00 to 6/30/01  
FY02 - 7/1/01 to 6/30/02

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Department of Public Health  
and Human Services

**SECTION:**

PROVISION OF SERVICES

HOME HEALTH SERVICES

**SUBJECT:**

Licensure Requirements

**REQUIREMENT:** As a condition of participation in the Montana Medicaid Program, all providers must abide by all applicable state and federal statutes, regulations, and rules governing licensure and certification.

**AGENCY**

**REQUIREMENTS:** The provider agency is responsible for insuring that all professionals working within the Medicaid Home Health Program are properly licensed. Any individual who provides service without proper licensure will be reported to the Business Standards Division of the Department of Labor and Industry.

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Department of Public Health  
and Human Services

## SECTION:

SERVICE COORDINATION

HOME HEALTH SERVICES

## SUBJECT:

Alternative Services

**PURPOSE:** The Medicaid home health benefit is designed to provide services to eligible individuals. The Department requires that an agency document the absence of other services when providing home health services to an eligible individual who cannot reasonably obtain medical services except through a home health agency. Consider the following alternatives to home health services when making this determination:

SERVICE	EXAMPLES	ALTERNATIVES TO HOME HEALTH
Skilled Nursing	Medication Set-up	Pharmacies, MD offices, family, Self-Directed Personal Assistance, Developmental Disability Programs
	Chronic Long Term Care	Private duty nursing services for children or under the Home and Community Based Services Program, programs for the developmentally disabled, or Self-Directed Personal Assistance
	Lab Work	Labs, MD offices
	Nonskilled tasks	Personal Assistance Services
Therapy	Restorative Only - Maintenance therapy is not a covered benefit	Outpatient, community-based providers, clinics, school-based services.

If a provider fails to document the reasons for providing home health services to an eligible individual who cannot obtain medical services except through a home health agency, reimbursement for services may be recovered.

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Department of Public Health  
and Human Services

SECTION:

SERVICE COORDINATION

HOME HEALTH SERVICES

SUBJECT:

Reserved for future use.

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Department of Public Health  
and Human Services

## SECTION:

SERVICE COORDINATION

HOME HEALTH SERVICES

## SUBJECT:

Developmental Disabilities

Effective October 1, 1999, the Disability Services Division began providing chronic nursing services for developmentally disabled individuals. Chronic care is defined as ongoing care from a nurse needed to meet the needs that result from what are generally permanent medical conditions. These routine services would include routine injections, bowel care program, catheter care, medication setup, insulin draws, blood sugars, routine assessments, and pedicures. It may also include other nursing services that are maintenance in nature.

Any individual with a diagnosis of developmental disability (or a related disorder) must obtain chronic nursing services through an approved provider of the Disability Services Division. To make this referral or to obtain clarifications on a specific case contact the local Regional Program Officer. (Refer to HH 803.)

Individuals with developmental disabilities will continue to have access to skilled nursing for acute needs and home based therapies if they qualify under the rules of the Medicaid Home Health program. This type of skilled nursing care would be for a limited time period associated with recovery from an accident, wound care, or acute hospitalization.

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Department of Public Health  
and Human Services

SECTION:

SERVICE COORDINATION

HOME HEALTH SERVICES

SUBJECT:

Personal Care Facilities/  
Adult Foster Homes

PERSONAL CARE FACILITIES (PCF)--A PCF can employ an RN, contract with an RN, or if the owner or staff are nurses, they can provide nursing services up to 20 consecutive days within the scope of practice. If the resident needs more than 20 consecutive days of nursing, the nursing must be provided by a source outside the arrangement by or employment of the PCF. The resident could receive services from a HH agency or receive private duty nursing services.

Medicaid home health services are available when the individual meets all program conditions and the service is not being covered through the payment to the PCF.

ADULT FOSTER HOMES (AFH)--Recipients residing in Adult Foster Homes may receive Medicaid home health services if they meet all program conditions. The owner or staff of the adult foster care home may not do nursing tasks with the residents even if the owner or staff are nurses.

General questions regarding the delivery of nursing services in AFHs and PCFs should be directed to the Licensing Bureau of the Quality Assurance Division at 444-2676.

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Department of Public Health  
and Human Services

## SECTION:

SERVICE COORDINATION

HOME HEALTH SERVICES

## SUBJECT:

Home Infusion Therapy

Requirements: In order to bill for skilled nursing services provided in conjunction with home infusion therapy services, the following must apply:

1. The individual must meet program eligibility, including the service criteria; and
2. Nursing services are not available through the home infusion provider.

If a home health agency is also licensed as a home infusion therapy agency and employs nurses for that purpose, it is expected that the nursing services will come through the home infusion program and not the home health benefit. The home infusion therapy agency can be reimbursed for the nursing by enrolling as a private duty nursing provider.

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Department of Public Health  
and Human Services

**SECTION:**

SERVICE COORDINATION

HOME HEALTH SERVICES

**SUBJECT:**

Coordination with Home and  
Community Based Services

The Home and Community Based Services (HCBS) program is the community alternative to physically disabled or elderly individuals requiring nursing facility services. This program is based on availability of slots or funding. Therefore a person may qualify, but service may not be available.

The core component of HCBS is case management services. Each enrolled individual is associated with a case management team. Each team consists of both registered nurses and social workers. Their primary responsibility is to insure the needs of HCBS individuals are being met through the utilization of HCBS or state plan services such as home health, personal assistance, hospice, durable medical equipment, and the like.

Some individuals receiving home health services may be enrolled in the HCBS program. The home health agency should check with the individual's case manager to promote the continuity of care and exchange information as necessary.

To receive additional information regarding the HCBS program, contact a case management team in your area. A list of such teams is located at HH 807.

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Department of Public Health  
and Human Services

## SECTION:

SERVICE COORDINATION

HOME HEALTH SERVICES

## SUBJECT:

Coordination with Personal  
Assistance Services

Personal Assistance services are available to Medicaid eligible individuals who require assistance with the activities of daily living which is supported by a medical diagnosis and verified by their physician. The personal assistance program can provide help with bathing, dressing, grooming, ambulation, exercise, transfers, meal prep, and eating. Some individuals may also receive assistance with household tasks and escort to medical services.

Referrals should be made to the personal assistance program for individuals who can not manage their activities of daily living. This service is considered equally safe and effective as well as less costly than home health aide services.

In the case of dually eligible individuals, **Medicare** home health aide services normally pay prior to Medicaid personal assistance services. Two situations may occur. One, if the individual being admitted to home health services is eligible for the **Medicare** benefit, Medicaid personal assistance services are available to supplement **Medicare** services. Or secondly, if the individual being admitted to home health services is already enrolled in the Medicaid personal assistance services benefit, for the purpose of continuity of care, those individuals do not need to be admitted to the **Medicare** home health benefit.

A list of Medicaid approved personal assistance providers can be found at HH 805.

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Department of Public Health  
and Human Services

**SECTION:**

SERVICE COORDINATION

HOME HEALTH SERVICES

**SUBJECT:**

Coordination with Self-  
Directed Personal Assistance  
Services

Self-Directed personal assistance services are available to Medicaid eligible individuals who require assistance with the activities of daily living which is supported by a medical diagnosis, verified by their health care professional and capable of managing their services.

These individuals must assume the responsibility for hiring, firing, managing, scheduling and training their attendants. They are also responsible for maintaining back-up services in the event their scheduled attendant does not show.

The self-directed personal assistance program can provide help with bathing, dressing, grooming, ambulation, exercise, transfers, meal prep, and eating. Some individuals may also receive assistance with household tasks and escort to medical services. In addition, an exemption from the nurse practice act allows participants in this program to direct their attendants in providing bowel care, urinary systems management, medication administration, and wound care. If a recipient chooses to manage one or all of these health maintenance activities, home health services are not available for the same activity. This would be considered a duplication of services.

All individuals participating in the self-direct program have a current copy of their plan of care. To verify the type of services the individual is receiving, review this plan or speak to the providing agency.

To learn more about the self-directed personal assistance program, contact your local Regional Program Officer or self-direct agency. For a list of agencies refer to HH 806.

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Department of Public Health  
and Human Services

## SECTION:

SERVICE COORDINATION

HOME HEALTH SERVICES

## SUBJECT:

Pregnant Women

Pregnant women are not considered eligible solely based upon their pregnant state. However, there are instances where complications arise and women are ordered to strict bed rest. When it poses eminent danger to the mother or unborn child to travel for medical care, home health agency services may be ordered by the attending physician. These women should also be referred to Targeted Case Management for High Risk Pregnant Women.

If the condition passes or delivery is completed, the home health agency must terminate services. Follow up care is the responsibility of the attending physician.

Services provided to care for the mother's young children while she remains on bed rest is not a benefit of the home health program or the personal assistance program. Targeted Case Management can address these issues.

Services provided solely to educate the mother about breast feeding, child rearing, proper care and nutrition are not a benefit of the home health program. These services can be provided by local county health departments, the discharging hospital, and family physicians.

Services provided solely to follow-up on a normal vaginal or Cesarean section delivery are not a benefit of the home health program. These services are the responsibility of the attending physician.

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Department of Public Health  
and Human Services

HOME HEALTH SERVICES

SECTION:

SERVICE COORDINATION

SUBJECT:

Services to Children

DEFINITION--Federal Medicaid law defines children as individuals who have not yet reached their 21st birthday.

NURSING--The Montana Medicaid program covers private duty nursing (PDN) services for non-institutionalized children requiring complex care for conditions of such medical severity or complexity that skilled nursing care is required. All private duty nursing services require prior authorization by the Mountain Pacific Quality Health Foundation (Foundation). Authorization is based upon the severity of the task and the time required to perform a skilled nursing task.

Services may include:

1. Skilled nursing services provided by a registered or licensed practical nurse; or
2. Patient specific training provided to an RN or LPN when a recipient is new to a nursing agency, when a change in condition of the recipient requires additional training for the current nurse, or when a change in nursing personnel require a new nurse to be trained to care for the recipient.

Home health services are not available to children who qualify for PDN service. PDN is considered equally safe and effective to and less costly than home health services. If a PDN provider is not available, home health services may be provided. However, it must be documented in the recipient's chart that PDN services were not available. If PDN services become available, the home health agency must transfer the case to the PDN agency. The department may review such cases.

## SECTION:

SERVICE COORDINATION

## SUBJECT:

Services to Children

Services provided by a home health agency for the sole purpose to oversee the private duty nursing provider, or case management services are not reimbursable. This is considered a duplicate service.

THERAPIES--Children are not eligible based solely upon their age. Home health therapy services are available only when the child is considered so medically fragile that leaving the home poses eminent danger. Home health therapy services are not to be provided only as a convenience to parents. If a parent should need to travel to obtain care for their child, reimbursement for transportation may be available through the Medicaid transportation program. These services are prior authorized by the Foundation at 443-6100 (Helena) or 1-800-292-7114 (statewide).

HOME HEALTH AIDE--Individuals who qualify for Personal Assistance Services do not qualify for Home Health Aide services. If such service is being requested, refer the family to a personal assistance provider. The Personal Assistance program authorizes care based upon age appropriateness of the child. For example, all 2 year children need assistance with their personal care needs, therefore no assistance would be provided. A ten year old would be treated differently.

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Department of Public Health  
and Human Services

HOME HEALTH SERVICES

SECTION:

DIRECTORIES

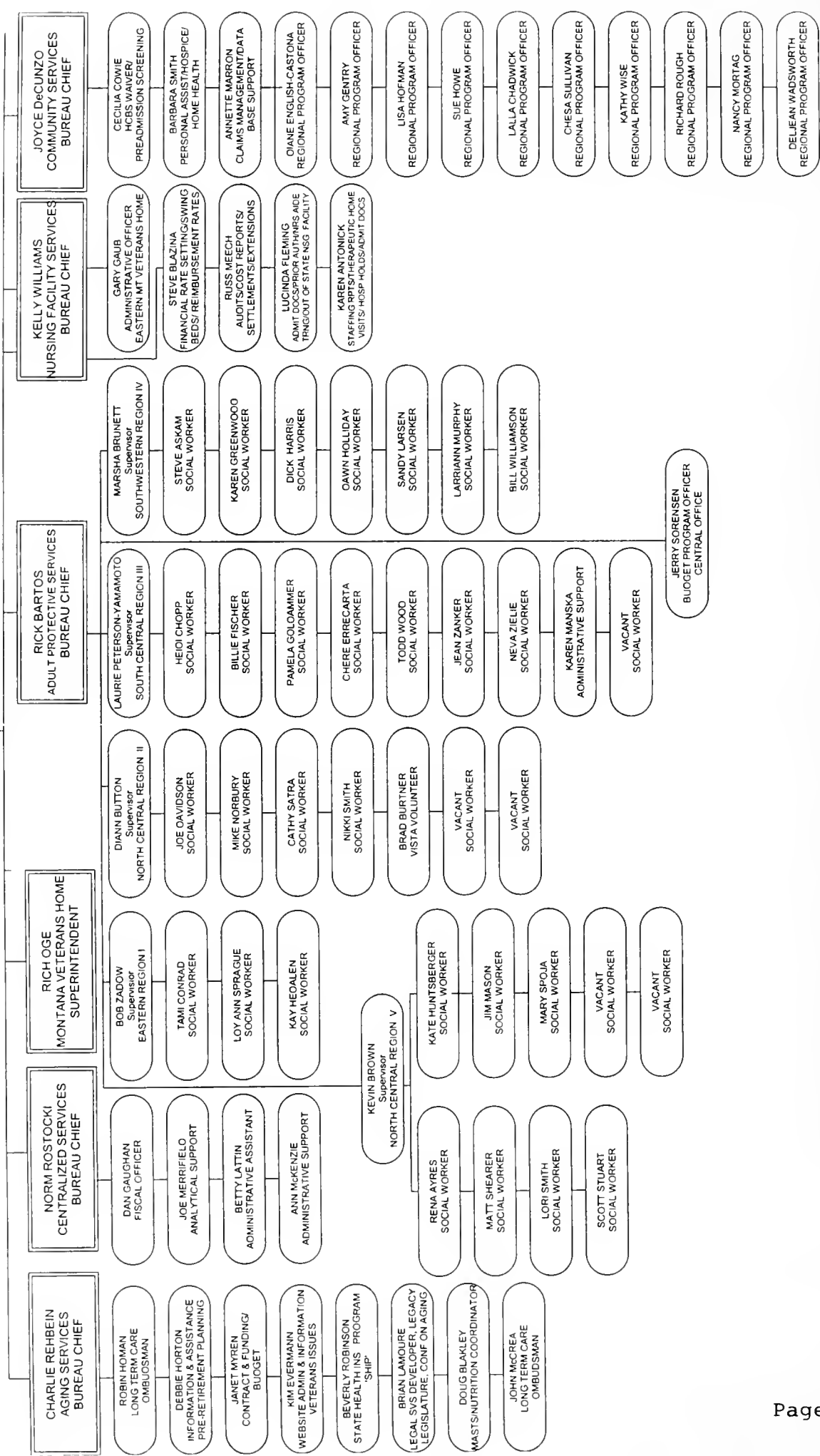
SUBJECT:

Division Organization Chart

Following is the organization chart of the  
Senior and Long Term Care Division.

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MIKE HANSHEV, Administrator  
SENIOR AND LONG TERM CARE DIVISION



Department of Public Health  
and Human Services

SECTION:  
APPENDIX

HOME HEALTH SERVICES

SUBJECT:  
Directory of Community Services  
Bureau-Central Office Staff

Community Services Bureau  
Senior & Long Term Care Division  
P.O. Box 4210  
Helena, MT 59604-4210

Joyce DeCunzo, Bureau Chief

Barb Smith, Program Manager  
Home Health Services  
Personal Assistance Services  
Self-Directed Personal Assistance Services  
Hospice Services

Cecilia Cowie, Program Manager  
Home and Community Based Services  
Preadmission Screening

Annette Marron, Program Specialist  
Claims  
State Supplemental Payment Program

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Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME HEALTH SERVICES

## SUBJECT:

Directory of Regional Program  
Officers

Kathy Wise Senior & Long Term Care Division 1211 Grand Avenue #211 Billings, MT 59102	Phone: 247-2650 Fax: 245-9437	Big Horn, Carbon, Golden Valley, Musselshell, Stillwater, Treasure, Wheatland, Yellowstone
Lalla Chadwick Senior & Long Term Care Division 202 South Black Bozeman, MT 59715	Phone: 586-4089 Fax: 587-7863	Gallatin, Madison, Park, Sweetgrass
Chesa Sullivan Senior & Long Term Care Division 700 Casey Butte, MT 59701	Phone: 496-4989 Fax: 782-8728	Beaverhead, Deer Lodge, Granite, Silver Bow
Susan Howe Senior & Long Term Care Division 218 West Bell, Suite 205 Glendive, MT 59330	Phone: 377-6252 Fax: 377-1240	Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone, Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Valley, Wibaux
Nancy Mortag Deljean Wadsworth Senior & Long Term Care Division 201 1st Street South Great Falls, MT 59405	Phone: 453-8902 Phone: 453-8975 Fax: 454-6084	Blaine, Cascade, Choteau, Fergus, Glacier, Hill, Judith Basin, Liberty, Petroleum, Phillips, Pondera, Teton, Toole
Diane English-Castona Senior & Long Term Care Division 3075 N Montana Ave PO Box 202958 Helena, MT 59620-2958	Phone: 444-1707 Fax: 444-9659	Broadwater, Jefferson, Lewis & Clark, Meagher, Powell, Montana State Hospital Long Term Care Unit

## SECTION:

APPENDIX

## SUBJECT:

Directory of Regional Program  
Officers

Richard Rough Senior & Long Term Care Division 2282 Hwy 93 S P.O. Box 2357 Kalispell, MT 59903-2357	Phone: 755-5420 Fax: 751-5944	Flathead, Lake, Lincoln
Amy Gentry Lisa Hofman Senior & Long Term Care Division 2677 Palmer, Ste 240 Missoula, MT 59808	Phone: 329-1312 329-1310 Fax: 329-1313	Mineral, Missoula, Ravalli, Sanders

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Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME HEALTH SERVICES

## SUBJECT:

Directory of Home Health  
Providers

PROVIDER	PHONE NUMBER	COUNTIES
Pintler Home Health Alice Cortright 200 Main St, Ste 103 Anaconda, MT 59711	563-5848	Deer Lodge
Fallon Medical Complex Home Care Sandy Kinsey, RN 205 S 4th St W PO Box 820 Baker, MT 59313	778-3331	Fallon, Carter
Big Sandy Medical Center Home Care Marlene Baker 3 Montana Ave PO Box 530 Big Sandy, MT 59520	378-2188	Chouteau
Yellowstone City-County Health Dept 123 S 27th St PO Box 35033 Billings, MT 59107	247-3240	Carbon, Golden Valley, Musselshell, Yellowstone
Rocky Mountain Home Care Lila Montoya, RN 2110 Overland Ave Ste 114 Billings, MT 59102	652-8883	Yellowstone
City-County Home Health Service Terri Hocking, RN 25 W Front St Butte, MT 59701	723-3282	Silver Bow

## SECTION:

APPENDIX

## SUBJECT:

Directory of Home  
Health Providers

PROVIDER	PHONE NUMBER	COUNTIES
Beta Factor Home Care Inc Deborah Boyle 312 S Clark St Butte, MT 59701	782-9089	Silver Bow
Liberty County Home Health Agency Dana Siedel PO Box 705 Chester, MT 59522	759-5181	Liberty
Stillwater Community Hospital Tim Russell Home Health Agency 44 W 4th Ave N Columbus, MT 59019	322-5316	Stillwater
Pondera Home Health Agency Vicki Newmiller 809 Sunset Blvd Ste 4 Conrad, MT 59425-1600	278-5566	Pondera, Glacier, Northern Cheyenne Reservation
Glacier Medical Home Health Agency Marianne Wilson 802 2nd St SE Cut Bank, MT 59427	873-2251	Glacier
Barrett Memorial Hospital Marie Holt Home Care Service 1260 S Atlantic Dillon, MT 59725	683-9221	Beaverhead
Granite County Home Health Harriet Mentzer, RN PO Box 312 Drummond, MT 59832	288-3627	Granite

## SECTION:

APPENDIX

## SUBJECT:

Directory of Home  
Health Providers

PROVIDER	PHONE NUMBER	COUNTIES
Missouri River Medical Center Jay Pottenger Home Health Agency PO Box 249 Fort Benton, MT 59442	622-3331	Chouteau
Frances Mahon Deaconess Hospital Randall Holom Home Health Agency 621 Third St S Glasgow, MT 59230	228-4351	Valley, Phillips
Glendive Medical Center Adelaide Kopp Home Care 202 Prospect Ave Glendive, MT 59330	365-3306	Dawson, McCone, Prairie
Benefis Home Health Jeanne Duncan 1101 26th St S Great Falls, MT 59405	455-5197	Cascade, Chouteau, Judith Basin, Lewis & Clark, Pondera, Teton
Medallion Medical Care Val Shuman, RN 401 15th Ave S Ste 209 Great Falls, MT 59405	454-3883	Cascade
Marcus Daly Memorial Hospital Jane Hron Home Health Agency 708 S 1st St Hamilton, MT 59840	363-6503	Ravalli
Wheatland Memorial Home Health Lori Pritchard PO Box 287 Harlowton, MT 59036	632-4351	Wheatland

## SECTION:

APPENDIX

## SUBJECT:

Directory of Home  
Health Providers

PROVIDER	PHONE NUMBER	COUNTIES
Northern Montana Home Health Care David Henry 110 W 13th St PO Box 1231 Havre, MT 59501	262-1461	Hill, Blaine
Home Link of St Peter's Sheila Cotter 201 S California Helena, MT 59601	444-2244	Lewis & Clark, Jefferson
Westmont Home Health Services 2525 Colonial Dr PO Box 5059 Helena, MT 59604	443-4140	Broadwater, Jefferson, L&C, Madison, Meagher, Park, Teton, Sweet Grass
Home Options-Home Health Judy Graham 175 Commons Loop Ste 100 Kalispell, MT 59901	752-8689	Flathead
Central Montana Medical Center Michelle Foy Home Health Agency PO Box 580 Lewistown, MT 59457	538-7711	Judith Basin, Fergus
St John's Lutheran Hospital Susan Horelick Home Health Service 350 Louisiana Ave Libby, MT 59923	293-0180	Lincoln
Livingston Memorial Home Care Julia Jardine 504 S 13th St Livingston, MT 59047	222-5030	Park

## SECTION:

APPENDIX

## SUBJECT:

Directory of Home  
Health Providers

PROVIDER	PHONE NUMBER	COUNTIES
Phillips County Hospital Larry Putnam Home Health Agency PO Box 640 Malta, MT 59538	654-1100	Phillips, Fort Belknap
Holy Rosary Hospital Dee Abbott Home Care Department 2600 Wilson St Miles City, MT 59301	233-3810	Custer, Powder River
Home Health Care Rhonda Bergland 242 Kemp St Missoula, MT 59801	541-1800	Missoula
Partners in Home Care Barb Fabey 500 N Higgins Suite 201 Missoula, MT 59802	728-8848	Missoula, Mineral
Clark Fork Valley Linda Shrock Home Health Agency PO Box 768 Plains, MT 59859	826-3601	Sanders
Sheridan Memorial Home Health Linda Heppner 440 W Laurel Ave Plentywood, MT 59254	765-1420	Sheridan, Daniels
St Joseph Hospital Corp Maggie Darlington Home Health Agency PO Box 1010 Polson, MT 59860	883-5377	Sanders, Lake

## SECTION:

APPENDIX

## SUBJECT:

Directory of Home  
Health Providers

PROVIDER	PHONE NUMBER	COUNTIES
Roosevelt County Home Health Care Arlee Fox PO Box 38 Poplar, MT 59255	768-3452	Roosevelt
Beartooth Hospital & Health Center Kris Reitz 600 W 21st St PO Box 590 Red Lodge, MT 59068	446-0050	Carbon
Lake County Home Health Agency Pam Fisher 711 Main St SW Ronan, MT 59864	676-7300	Lake, Sanders
Daniels Memorial Hospital Mary Nyhus Home Health Agency PO Box 400 Scobey, MT 59263	487-2296	Daniels, Sheridan
Marias Medical Center Home Health Kate Davis 640 Park Dr PO Box 915 Shelby, MT 59474	434-3283	Toole
Ruby Valley Hospital Steve Lang Home Health Agency PO Box 336 Sheridan, MT 59749	842-5453	Madison
Sidney Health Center Home Health Nancy Dynneson 216 14 Ave SW Sidney, MT 59270	482-2120	Richland

## SECTION:

APPENDIX

## SUBJECT:

Directory of Home  
Health Providers

PROVIDER	PHONE NUMBER	COUNTIES
Broadwater Health Center Nancy Taylor Home Health Agency PO Box 519 Townsend, MT 59644	266-3186	Broadwater
Mountain View Home Health Agency Katherine Campbell PO Box Q White Sulphur Springs, MT 59645	547-3321	Meagher
Flathead County Home Health Agency Casey Blumenthal, RN 711 E 13th St Whitefish, MT 59937	862-9030	Flathead

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Department of Public Health  
and Human Services

## SECTION:

DIRECTORIES

HOME HEALTH SERVICES

## SUBJECT:

Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Fallon Medical Complex-Home Care Leslie O'Donnell 202 S 4th St W P.O. Box 820 Baker, MT 59313	Phone: 778-2824 Fax: 778-3436	Carter, Fallon
Alternative Nursing Services Christina Clark 18519 Lake Shore Dr Bigfork, MT 59911	Phone: 982-3080 Fax: 982-3080 (call first)	Flathead, Lake
Western Medical Services Jan Hawley 705 Lincoln Lane Billings, MT 59105	Phone: 245-6356 Fax: 245-1224	Carbon, Bighorn, Musselshell, Stillwater, Yellowstone
YCCHD/Private Duty Program Carol Pfau 123 S 27th PO Box 35033 Billings, MT 59107	Phone: 247-3270 Fax: 247-3202	Big Horn, Carbon, Golden Valley, Musselshell, Yellowstone
Chippewa Cree Clinic Yvonne Hill PO Box 664 Box Elder, MT 59521	Phone: 395-4486 Fax: 395-4408	Rocky Boy Reservation

## SECTION:

DIRECTORIES

## SUBJECT:

Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Home Care Services Rosemarie Jones 321 E Main, Ste 210 PO Box 877 Bozeman, MT 59715	Phone: 582-1680 800-555-3111 Fax: 582-1569	Beaverhead, Big Horn, Broadwater, Carbon, Custer, Daniels, Dawson, Gallatin, Golden Valley, Jefferson, Lake, Madison, McCone, Mineral, Missoula, Musselshell, Park, Phillips, Powder River, Prairie, Ravalli, Richland, Roosevelt, Rosebud, Sheridan, Stillwater, Sweetgrass, Treasure, Valley, Yellowstone, and Northern Cheyenne Reservation
Blackfeet PCA Program Terry Flamand P.O. Box 1070 Browning, MT 59417	Phone: 338-3482 Fax: 338-3480	Blackfeet Indian Reservation, Glacier, Pondera, Toole
MT Easter Seals Personal Care Program Alberta Lopez 3703 Harrison Butte, MT 59701	Phone: 533-0020 Fax: 533-0019	Deer Lodge, Granite, Jefferson, Powell, Silver Bow
MT Easter Seals Personal Care Program Linn Wright PO Box 115 Choteau, MT 59422	Phone: 466-5606 Fax:	Teton
Valley View Home Dave Odegaard 1225 Perry Ln Glasgow, MT 59230	Phone: 228-2461 Fax: 228-4831	
MT Easter Seals Personal Care Program Gretchen Olson 4400 Central Ave Great Falls, MT 59405	Phone: 771-3777 Fax: 761-5110	Cascade

## SECTION:

DIRECTORIES

## SUBJECT:

Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Spectrum Medical Inc Deana Drew 2526 12th Ave S Great Falls, MT 59405	Phone: 727-9322 800-870-9322 Fax: 771-8337	Beaverhead, Blaine, Cascade, Choteau, Deer Lodge, Granite, Hill, Lewis & Clark, Pondera, Powell, Silver Bow, Teton, Toole
Caring Hands Home Care Services Bonnie Pratt 825 10 <sup>th</sup> St S Great Falls, MT 59405	Phone: 454-9099 Fax: 454-3261	Blaine, Cascade, Choteau, Glacier, Hill, Ponders, Teton, Toole
Tribal Health - Fort Belknap Agency Loretta Bell RR1 Box 66 Harlem, MT 59525	Phone: 353-8360 Fax: 353-2884	Fort Belknap Reservation
Hill County Area X Agency on Aging Evelyn Havskjold, Director 2 West Second St Havre, MT 59501	Phone: 265-5464 Fax: 265-5487	Hill
HomeLink of St. Peter's Sheila Cotter 2475 Broadway Helena, MT 59601	Phone: 444-2244 Fax: 447-2723	Jefferson, Lewis & Clark
WestMont Home Health Services 2525 Colonial Drive P.O. Box 5059 Helena, MT 59604	Phone: 443-4140 800-735-6467 Fax: 447-3144	Beaverhead, Blaine, Broadwater Cascade, Chouteau, Dawson, Deer Lodge, Gallatin, Glacier, Hill, Jefferson, Lewis and Clark, Liberty, Madison, Park, Pondera, Richland, Roosevelt, Silver Bow, Sweet Grass, Teton, Toole, Yellowstone

## SECTION:

DIRECTORIES

## SUBJECT:

Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Personal Touch Home Care Karen Gendreau 214 Main P.O. Box 8300 Kalispell, MT 59904-1300	Phone: 758-5422 Fax: 752-6582	Flathead
Western Medical Kris Carlson 2707 Hwy 93 S Kalispell, MT 59901	Phone: 755-4968 Fax: 752-5157	Kalispell - Flathead, Glacier, Lake, Lincoln, Sanders
In Home Personal Care Nancy Berg 629 NE Main Lewistown, MT 59457	Phone: 538-6302 Fax: 538-6306	Fergus, Judith Basin
Phillips County Hospital Association Sue Davis 417 S 4th St E PO Box 640 Malta MT 59538	Phone: 654-1100 ex 43 Fax: 654-2876	Phillips, Fort Belknap Reservation
Nightingale Nursing Bill Woody 110 South Ave W Missoula, MT 59801	Phone: 541-1700 800-357-4799 Fax: 541-1703	Missoula, Ravalli
Partners in Home Care Barb Fabey 500 N Higgins, Ste 201 Missoula, MT 59802	Phone: 728-8848 Fax: 549-8970	Missoula
Home Caregivers, Inc. Kathy Skates 407 Second St W PO Box 747 Polson, MT 59860	Phone: 883-3590 Fax: 883-1923	Lake, Lincoln, Sanders

## SECTION:

DIRECTORIES

## SUBJECT:

Personal Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Sidney Health Center Home Health Nancy Dynneson 216 14th Avenue SW Sidney, MT 59270	Phone: 488-2243 Fax: 488-2155	Richland
Accessible Space Inc. Lynda Adams 2550 University Ave #330N St. Paul, MN 55114	Phone: 800-466-7722 Fax: 651-645-0541  Kris Kleinschmidt Southwinds, Gt Falls Phone: 771-1896 Fax: 771-7008	Cascade

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Department of Public Health  
and Human Services

## SECTION:

DIRECTORIES

HOME HEALTH SERVICES

## SUBJECT:

Self-Directed Personal  
Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Home Care/Fallon Medical Complex Leslie O'Donnell 202 S. 4th St. W. P.O. Box 820 Baker, MT 59313	Phone: 778-2824 Fax: 778-3436	Carter, Fallon
Alternative Nursing Services Christina Clark 18519 Lake Shore Dr Bigfork, MT 59911	Phone: 982-3080 Fax: 982-3080 (call first)	Flathead, Lake
LIFTT 929 Broadwater Sq Billings MT 59101	Phone: 259-5181 Fax: 259-5259	Big Horn, Carbon, Carter, Custer, Fallon, Garfield, Golden Valley, McCone, Mussellshell, Powder River, Prairie, Richland, Rosebud, Stillwater, Treasure, Wibaux, Yellowstone
Western Medical Services Jan Hawley 705 Lincoln Lane Billings, MT 59105	Phone: 245-6356 Fax: 245-1224	Yellowstone, Bighorn, Carbon, Musselshell, Stillwater
North Central Independent Living Ctr Sharlo LaFountain 1120 25th Ave NE Black Eagle, MT 59414	Phone: 452-9834 800-823-6245 Fax: 453-3940	Blaine, Cascade, Chouteau, Daniels, Fergus, Glacier, Hill, Judith Basin, Liberty, Phillips, Pondera, Petroleum, Roosevelt, Sheridan, Teton, Toole, Valley

## SECTION:

DIRECTORIES

## SUBJECT:

Self-Directed Personal  
Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Home Care Montana Rosemarie Jones 321 E Main, Ste 210 PO Box 877 Bozeman, MT 59711	Phone: 582-4436 877-582-4436 Fax: 582-1569	Statewide
Blackfeet PCA Program Terry Flamand P.O. Box 1070 Browning, MT 59417	Phone: 338-3482 Fax: 338-3480	Blackfeet Indian Reservation, Glacier, Pondera, Toole
Valley View Home Dave Odegaard 1225 Perry Ln Glasgow, MT 59230	Phone: 228-2461 Fax: 228-4831	Valley
Caring Hands Home Care Services Bonnie Pratt 825 10 <sup>th</sup> St S Great Falls, MT 59405	Phone: 454-9099 Fax: 454-3261	Cascade
Spectrum Medical Inc Deana Drew 2526 12th Ave S Great Falls, MT 59405	Phone: 727-9322 800-870-9322 Fax: 771-8337	Beaverhead, Blaine, Cascade, Choteau, Deer Lodge, Granite, Hill, Lewis & Clark, Pondera, Powell, Silver Bow, Teton, Toole
MT Independent Living Project Julie Rice 1130 Butte PO Box 5415 Helena MT 59604	Phone: 442-5755 Fax: 442-1612	Beaverhead, Broadwater, Deer Lodge, Gallatin, Granite, Jefferson, Lewis & Clark, Madison, Meagher, Park, Powell, Silver Bow, Sweetgrass, Wheatland
Western Medical Services Kris Carlson 1117 S Main Kalispell, MT 59901	Phone: 755-4968 Fax: 752-5157	Kalispell - Flathead, Glacier, Lake, Lincoln, Sanders

## SECTION:

DIRECTORIES

## SUBJECT:

Self-Directed Personal  
Assistance Providers

PROVIDER	PHONE NUMBER	COUNTIES
Express Personnel Service Vicki Sutton 3709 Brooks Missoula, MT 59801	Phone: 543-6651 Fax: 543-7288	Flathead, Lake, Mineral, Missoula, Ravalli, Sanders
Nightingale Nursing Bill Woody 800 Kensington, Ste 211 Missoula, MT 59801	Phone: 541-8700 866-492-8591 Fax: 541-8704	Statewide
Summit ILC Mike Mayer Professional Plaza 700 SW Higgins St, 101 Missoula, MT 59803	Phone: 728-1630 Fax: 829-3309	Flathead, Lake, Lincoln, Mineral, Missoula, Ravalli, Sanders
Home Caregivers Kathy Skates 407 Second St W PO Box 747 Polson, MT 59860	Phone: 883-3590 Fax: 883-1923	Lake, Lincoln, Sanders

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Department of Public Health  
and Human Services

## SECTION:

DIRECTORIES

HOME HEALTH SERVICES

## SUBJECT:

Case Management Teams

NAME & ADDRESS	STAFF	COUNTIES
Community Medical Center/Rehab HCBS Case Management 607 SW Higgins Missoula, MT 59803 Phone: 327-4585 Fax: 327-4484	Jayne Lux, RN Joann Haven, RN Laura Sherry, RN Sue Kirchmyer, RN Kathy Flynn, SW Tim Laskowski, SW Vickie Robeson, SW Ruby Finch, RN	Mineral, Missoula, Ravalli
Partners in Home Care 500 N. Higgins, Ste 201 Missoula, MT 59801 Phone: 728-8848 Fax: 549-8970	Marlene Swisher, RN Ruth Cleveland, SW Susan Allen, SW	Mineral, Missoula, Ravalli
Yellowstone City-County Health Dept HCBS Case Management P.O. Box 35033 Billings, MT 59107 Phone: 247-3226 Fax: 247-3202	Ron McKenna, SW Tris Newell, RN Linda Collins, RN Dee Dee Chiesa, SW Jill Egan, SW Kaye Blair, RN	Big Horn, Carbon, Rosebud, Stillwater, Sweetgrass, Treasure, Yellowstone
Easter Seal HCBS Case Management 4400 Central Ave Great Falls, MT 59405 Phone: 761-3680 Fax: 761-5110	Karla Egan, LPN Tari Barkley, SW Mickie Anderson, RN Kathy Smith, RN Stu Lekander, SEAS Ruby Howington, SW	Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, Toole
District IX HRDC HCBS Case Management 321 E. Main, Ste 300 Bozeman, MT 59715 Phone: 586-3134 Fax: 585-3538	Barb Hilton, RN Charlene Findlay, SW Stacey Nelson, SW	Gallatin, Park, Madison, Meagher

## SECTION:

DIRECTORIES

## SUBJECT:

Case Management Teams

NAME & ADDRESS	STAFF	COUNTIES
L&C City-Co Health Dept HCBS Case Management 1930 9th Ave, Ste 207 Helena, MT 59601 Phone: 443-2584 Fax: 447-1665	Jeanne Underhill, RN Kristi Heilman, RN Dana Gibson, SW Trace O'Connell, SW	Broadwater, Jefferson, Lewis and Clark
Holy Rosary Home Care HCBS Case Management 2600 Wilson St #30 Miles City, MT 59301 Phone: 233-3810 Fax: 233-7134	Bev Askin, RN Laurie Ellinghouse, SW	Carter, Custer, Dawson, Fallon, Garfield, Powder River, Prairie, Rosebud, Wibaux
Sidney Health Center HCBS Case Management P.O. Box 1690 Sidney, MT 59270 Phone: 488-2140 Fax: 482-5514	Robin Bender, RN Kerry Reitz, SW	Daniels, Dawson, McCone, Richland, Roosevelt, Sheridan, Valley
NW MT Human Resources HCBS Case Management P.O. Box 8300 Kalispell, MT 59904 Phone: 758-5422 Fax: 752-6582	Debbie Reimnitz, RN Sue Pratt, SW Marla Elliot, RN Emilianne Lansdown, SW	Flathead, Lake, Lincoln, Sanders
Spectrum Medical, Inc. HCBS Case Management 523 E. Front, Suite 529 Butte, MT 59701 Phone: 723-7987 Fax: 723-4120	Kevin Skocilich, SW Georgia Peterson, RN Virginia Mick, RN Staci Berceir, SW	Beaverhead, Deer Lodge, Granite, Powell, Silver Bow

## SECTION:

DIRECTORIES

## SUBJECT:

Case Management Teams

Central Montana Medical Center HCBS Case Management 408 Wendell Ave Lewistown, MT 59457 Phone: 538-6297 (Kathy) 538-6382 (Tara) Fax: 538-6267	Kathy Hodgeson, RN Tara Taylor, SW	Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Phillips Wheatland
Area II Agency on Aging HCBS Case Management 1504 Fourth Street W Roundup, MT 59072 Phone: 323-1320 Fax: 323-3859	Betty Jo Hiermeier, SW Stephanie Councill, RN	Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Musselshell, Petroleum, Stillwater, Sweet Grass, Wheatland, Yellowstone
Western Montana AAA HCBS Case Management 110 Main St Ste 5 Polson, MT 59860 Phone: 883-7284 Fax: 883-7363	John Freemole, SW Karen O'Donnell, RN	Lake, Lincoln, Mineral Ravalli, Sanders
Area VIII Agency on Aging HCBS Case Management 501 Bay Drive Great Falls, MT 59404 Phone: 454-6990 Fax: 454-6991	Nancy Swenson, SW Heather Mackenstadt, RN	Cascade
Area X Agency on Aging HCBS Case Management 2 W 2nd St Havre, MT 59501 Phone: 265-5464 Fax: 265-3611	Connie LaSalle, RN Lisa Passon, SW	Hill
Area XI Agency on Aging HCBS Case Management 227 West Front Missoula, MT 59802 Phone: 728-7682 Fax: 728-7687	Elizabeth Yahner  Polson 883-7284 John Freemole, SW Karen O'Donnell, RN	Missoula

## SECTION:

DIRECTORIES

## SUBJECT:

Case Management Teams

Area IV Agency on Aging 201 S Main PO Box 1717 Helena, MT 59624 Phone: 447-1680 Fax: 447-1629	Linda Simmons, SW Ruth Sasser, RN	Broadwater, Gallatin, Jefferson, Lewis & Clark, Meagher, Park
Area III Agency on Aging 501 Bay Drive Great Falls, MT 59404 Phone: 454-6990 Fax: 454-6991	Nancy Swenson, SW Heather Mackenstadt, RN	Chouteau, Glacier, Liberty, Pondera, Teton, Toole
Area V Agency on aging 523 E. Front, Suite 529 Butte, MT 59701 Phone: 723-7987 Fax: 723-4120	Virginia Mick, RN Staci Berceir, SW	Beaverhead, Deer Lodge, Grainite, Madison, Powell, Silver Bow

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Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME HEALTH SERVICES

## SUBJECT:

Directory of Hospice  
Providers

PROVIDER	PHONE NUMBER	COUNTIES
Anaconda Pintler Hospice Alice Cortright, Administrator 200 Main St P.O. Box 596 Anaconda, MT 59711	Phone: 563-5422 Fax: 563-5427	Deer Lodge
Big Sky Hospice Judy Stewart 123 S 27th St PO Box 35033 Billings, MT 59103-1049	Phone: 247-3200 Fax: 247-3202	Yellowstone
Gallatin Hospice Beth Overly 915 Highland Blvd Bozeman, MT 59715	Phone: 585-5500 Fax:	Gallatin
Highlands Hospice Loren Hines, Administrator 3703 Harrison Butte, MT 59701	Phone: 533-0020 Fax:	Silver Bow
Peace Hospice of Montana 300 N Virginia St #305 Conrad, MT 59425	Phone: 278-5566 Fax:	Pondera
Barrett Memorial Hospice Marie Holt 1260 S Atlantic Dillon MT 59725	Phone: 683-9221 Fax: 683-9216	Beaverhead

## SECTION:

APPENDIX

## SUBJECT:

Directory of Hospice  
Providers

PROVIDER	PHONE NUMBER	COUNTIES
Glendive Medical Center Paul Hanson Hospice Program 202 Prospect Dr Glendive MT 59330	Phone: 365-6921 Fax:	Dawson
Peace Hospice of Montana Mary Gray Columbus Hospital Corp PO Box 5013 Great Falls, MT 59404-5013	Phone: 727-9796 Fax:	Cascade
Hospice of the Bitterroot Jane Hron Marcus Daly Memorial 1150 Westwood Dr Ste H Hamilton, MT 59840	Phone: 363-6503 Fax:	Ravalli
Bear Paw Hospice David Henry Northern Montana Hospital PO Box 1231 Havre, MT 59501	Phone: 265-4907 Fax:	Hill
Hospice of St Peter's Sheila Cotter 2475 Broadway Helena, MT 59601	Phone: 444-2367 Fax:	Lewis & Clark
WestMont Hospice Bridget McGregor 2525 Colonial Dr Helena, MT 59601	Phone: 443-4140 Fax: 447-3144	Lewis & Clark
Home Options Hospice Judy Graham 1280 Burns Way Kalispell, MT 59901	Phone: 752-8667 Fax:	Flathead

## SECTION:

APPENDIX

## SUBJECT:

Directory of Hospice  
Providers

PROVIDER	PHONE NUMBER	COUNTIES
Hospice of Central Montana Kyle Hopstad 629 NE Main Lewistown, MT 59457	Phone: 538-7711 Fax:	Fergus
Gateway Hospice Julie Jardine 504 S 13th St Livingston, MT 59047	Phone: 222-3541 Fax:	Park
Holy Rosary Hospice H. Ray Gibbons 2600 Wilson Miles City, MT 59301	Phone: 233-2600 Fax:	Custer
Partners in Home Care Hospice Barb Fabey 500 N Higgins, Suite 201 Missoula, MT 59802	Phone: 728-8848 Fax:	Missoula
Lake County Home Health Hospice Carol Cahoon 830 1/2 Shoreline Drive PO Box 39 Polson, MT 59860	Phone: 883-7300 Fax: 883-7292	Lake
Sidney Health Center Hospice Don Rush 216 14th Ave SW Sidney, MT 59270	Phone: 482-2120 Fax:	Richland

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# Human and Community Services Division

## County Directors/Regional Policy Specialists

Updated 12/10/98

<b>JIM FAY</b>	<b>Beaverhead</b>
----------------	-------------------

Phone: 683-2142	(01)	2 South Pacific #9
FAX: 683-5080		Dillon, MT 59725

NOTE: FAX is currently being shared with VR until one is purchased FAX: 782-8728

Contact: Kathryn Buckley-Patton

<b>JEAN KUKES</b>	<b>Big Horn</b>
-------------------	-----------------

Phone: 665-1906	(02)	P. O. Box 426
FAX: 665-3675		Hardin, MT 59034

Contact: County Director or Mary Evans, Assistant who handles payroll, supplies, etc.

<b>TIM WHITNEY</b>	<b>Blaine</b>
--------------------	---------------

Phone: 357-2276	(03)	P. O. Box 1088
FAX: 357-2436		Chinook, MT 59523

Contact: Shirley Briese, Administrative Officer (Hill County - Phone: 265-4348)

<b>JUANITA MALLO</b>	<b>Broadwater</b>
----------------------	-------------------

Phone: 222-8000	(04)	217 South Main
FAX: 222-5742		Livingston, MT 59047

Contact: Nancy Clark

<b>NANCY AMBROSE</b>	<b>Carbon</b>
----------------------	---------------

Phone: 446-1302	(05)	206 North Broadway
FAX: 446-2640		P. O. Box 670
		Red Lodge, MT 59068

Contact: None

<b>GEORGE SHANLEY</b>	<b>Cascade</b>
-----------------------	----------------

Phone: 454-5640	(07)	P. O. Box 1546
FAX: 454-5697		1601 2 <sup>nd</sup> Avenue North
		3 <sup>rd</sup> Floor
		Great Falls, MT 59401

Contact: Jerry Medved, Administrative Officer.

**TIM WHITNEY****Chouteau**

Phone: 622-5432

(08)

1020 13<sup>th</sup> Street

FAX: 622-3848

P. O. Box 459

Fort Benton, MT 59442

Contact: None

**SUE MATTHEWS****Custer**

Phone: 233-3334

(09)

1010 Main Street

FAX: 233-3449

Courthouse Basement

Powder River

Miles City, MT 59301

(38)

Garfield

(17)

McCone

FAX: 637-2121

(29)

Prairie

(40)

Contact: Donna Orthman, Supervisor.

**JOAN BRENNER****Dawson**

Phone: 377-4314

(11)

207 West Bell

FAX: 377-5917

Glendive, MT 59330

Contact: In Joan's absence: Chris Croucher (Dawson County) 377-4314/Rita Hanley (Fallon County) 778-7120

**PATTY GUIBERSON****Deer Lodge**

Phone: 563-3448

(12)

307 East Park, Rm 305

FAX: 846-3257 Powell

Powell

Anaconda, MT 59711

FAX: 859-3817 Granite

(39)

Granite

(20)

Contact: Supervisor: Judy Barber-Anaconda, Mary Pat Brown-Deer Lodge and Debbie Seitz-Granite County.

**JOAN BRENNER****Fallon**

Phone: 778-2883

(13)

10 West Fallon Avenue

FAX: 778-2815

Carter

P. O. Box 759

(06)

Wibaux

Baker, MT 59313

(55)

Contact: Doris Hastig/Supervisor: None

**BONI BRAUNBECK****Fergus**

Phone: 538-7468  
FAX: 538-8419

(14)  
Musselshell  
(33)  
Judith Basin  
(23)  
Petroleum  
(35)  
Wheatland  
(54)  
Golden Valley  
(19)

300 1<sup>st</sup> Ave North  
Suite 201  
Lewistown, MT 59457

**Contact:** Supervisor/Cnty Contact: Barb Gilskey, FAIM Super. (538-7468)/Frances Hunter, Admin Ass't (538-7468).

**RULON J. GARDNER "JOHN" Flathead**

Phone: 751-5900 Main Number  
751-5921 Direct Number  
FAX: 751-5929

(15)

2282 Highway 93 So.  
P. O. Box 1096  
Kalispell, MT 59903

**Contact:** Judi Yeats, Gloria Stimson, Tammy Harmon

**JOAN DAVIES****Gallatin**

Phone: 582-3010  
FAX: 582-3114

(16)

237 West Main  
Bozeman, MT 59715

**Contact:** Supervisors: Deb Urdang, Anna Stallings

**PATTY LaPLANT****Glacier**

Phone: 338-3151  
FAX: 338-7769

(18)

P. O. Box 3025  
Browning, MT 59417

**Contact:** Darla Holm (Browning)/Lorraine Sherwin (Cut Bank).

**TIM WHITNEY****Hill**

Phone: 265-4348  
FAX: 265-6919

(21)  
Liberty  
(26)

Courthouse  
302 4<sup>th</sup> Avenue  
Havre, MT 59501

**Contact:** Supevisor: Shirley Briese/County Contacts: Shirley Briese, Valerie Golden

**JIM FAY****Jefferson**

Phone: 225-4045  
FAX: 225-4145

(22)

P. O. Box 836  
114 So. Washington  
Boulder, MT 59632

**Contact:** Colleen Llewellyn

**MARILYN BECKER****Lake**

Phone: 883-7820

(24)

8<sup>th</sup> and Main

FAX: 883-5320

P. O. Box 847

Polson, MT 59860

Contact: Sharon White, Luella Anderson

**JIM GREER****Lewis & Clark**

Phone: 444-1700

(25)

P. O. Box 5029

FAX: 444-1751

3075 North Montana

Helena, MT 59604

Contact: Jim Greer, 444-1720 OR Administrative Officer: Deborah Christiansen, 444-1721.

**SUSAN GOSNEY****Lincoln**

Phone: 293-3791

(27)

117 Commerce Way

FAX: 293-5549

Libby, MT 59923

Contact: Marlys Urdahl, Eligibility Specialist

**JOAN DAVIES****Madison**

Phone: 843-5324

(28)

313 East Idaho

FAX: 843-5325

P. O. Box 75

Virginia City, MT 59755

Contact: Patricia Pedula

**CAROLE GRAHAM****Missoula**

Voice Mail: 523-4994

Phone: 523-4950

(32)

301 West Alder

FAX: 721-4527 Missoula

Mineral

Missoula, MT 59802

Phone: 822-~~3217~~ Mineral  
4551

(31)

Contact: Patty Kelley, Kathy Gibson, Sue Rutherford, Karen Jirsa.

**JUANITA MALLO****Park**

Phone: 222-8000

(34)

217 South Main Street

FAX: 222-5742 Park

Meagher

Livingston, MT 59047

FAX: 547-3388 Meagher

(30)

Contact: Nancy Clark, Supervisor.

**DARLENE MILLER****Pondera**

**Phone:** 278-4020  
**FAX:** 278-4074 Pondera

(37)

**Courthouse**  
**20 4<sup>th</sup> Avenue SW**  
**Conrad, MT 59425**

**Phone:** 466-5721 Teton

**Teton**

**FAX:** 466-2349 Teton

(50)

**Phone:** 434-2371 Toole

**Toole**

**FAX:** 434-7293 Toole

(51)

**Contact:** Supervisor: Darlene Miller/Other: Terry Syvertson, Eligibility Assistant.

**JERI DRAKE****Ravalli**

**Phone:** 363-1944

(41)

**FAX:** 363-2138

**310 North 3<sup>rd</sup> Street**  
**Hamilton, MT 59840**

**Contact:** In Jeri Drake's absence: Lois Vallance

**LENA NEER****Richland**

**Phone:** 482-2282

(42)

**FAX:** 482-2015

**221 5<sup>th</sup> Street SW**  
**Sidney, MT 59270**

**Contact:** Lena Neer

**J. T. BROWNLEE****Roosevelt**

**Phone:** 653-1210

(43)

**FAX:** 653-2057

**Sheridan**  
(46)

**Courthouse Building**  
**Wolf Point, MT 59201**  
**100 West Laurel Avenue**  
**P. O. Box 413**  
**Plentywood, MT 59254**

**Daniels**  
(10)

**Contact:** J. T. Brownlee (Roosevelt) and Debra Maier (Sheridan/Daniels).

**BARBARA ROLSTON****Rosebud**

**Phone:** 356-2563

(44)

**FAX:** 356-7166

**P. O. Box 5016**  
**Forsyth, MT 59327**

**Phone:** 477-6251 Lame Deer Unit

**Treasure**

**FAX:** 477-6153 Lame Deer Unit

(52)

**Contact:** In Barbara Rolston's absence, Gloria Polley.

**THORNE JOHNSON****Sanders**

**Phone:** 827-4395

(45)

**FAX:** 827-4388

**OR** 827-9870

**Courthouse**  
**P. O. Box 519**  
**Thompson Falls, MT 59873**

**Contact:** In Thorne Johnson's absence, Marcie Tomas, Supervisor.

**JIM FAY****Silver Bow**

**Phone:** 496-4900 (47) 700 Casey Street  
**FAX:** 496-4901 (Effective 1/15/99) Butte, MT 59701  
**Contact:** If unable to contact Director, contact Mary Kay McGinnis in Silver Bow for any of three county combination or for a contact in physical location. Jefferson, Colleen Llewellyn.

**NANCY AMBROSE****Stillwater**

**Phone:** 322-5331 (48) 34 North 4<sup>th</sup> Street  
**FAX:** 322-4076 Sweetgrass P. O. Box 928  
 (49) Columbus, MT 59019

**Contact:** Supervisor: None/County Contacts: Carol Becken, Judie DeBock

**LINDA NYBAKKEN****Valley**

**Phone:** 228-8221 Ext: 50 (53) Courthouse Annex  
**FAX:** 228-4030 Valley Phillips 501 Court Square  
 (36) P. O. Box 9  
**FAX:** 654-2254 Phillips Glasgow, MT 59230  
**Contact:** Terri James, Eligibility Assistant

**GARY HUFFMASTER****Yellowstone**

**Phone:** 256-6950 (56) 111 North 31<sup>st</sup> Street  
**FAX:** 256-6996 Billings, MT 59101  
**Contact:** Supervisors: Marilyn Brush, Jan Patenade, Brenda Rush, Patty West/County Contacts: Lori Kelim, Marilyn Brush, Jan Patenaude, Brenda Rush, Patty West.





Department of Public Health and Human Services	SECTION:  APPENDIX
HOME HEALTH SERVICES	SUBJECT:  Medicaid Checklist

To insure that critical Medicaid criteria is being met, the Department developed the attached checklist. Use of this checklist is NOT mandatory and it does NOT guarantee payment of services. It will assist providers in meeting compliance criteria. The format is self-explanatory, however, should you need assistance contact your Regional Program Officer.

If utilized, this checklist should be completed at recertification. It will serve as a reminder to verify eligibility status, financial eligibility and dual eligibility issues. File this checklist in recipient charts with the HCFA 485.

o o o

# Medicaid Home Health Services Provider Checklist

Recipient Name:		DOB:		Medicaid ID#:	
Address:				Phone:	
Physician:		Passport: Y / N		Admit Date:	
Documentation of Recipient Eligibility Status: (See HH404)					
Remember: If the individual is not eligibile, documentation regarding the need to utilize home health services must exist.					
Verification of Medicaid Financial Eligibility: (See HH401)					
Completed by:			Month of eligibility:		
Spend Down Amount:			Restricted Card: Y / N		
Card:	FaxBack:	Voice Response:		OHS:	
Home Health Aide Serivces Prior Authorization: (See HH506)				Date:	
Complete SLTC-125, submit to Foundation for Approval:					
Dates of Service:				# of Visits:	
Explanation of Need:					
Dually Eligible: Y / N		Medicare #:		Part A / B	
Explanation of why Medicaid is being billed instead of Medicare. See HH403					
Remember if the individual's condition changes & becomes eligible for Medicare services, the payor source must change.					
Synopsis of Services:					

Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME HEALTH SERVICES

## SUBJECT:

Request for Initial Authorization  
(DPHHS-SLTC-124)

## DIRECTIONS:

Recipient Identifying Information--Complete the recipient identifying information.

Is this recipient under Passport?--Check the recipient's Medicaid card to determine if they are a PASSPORT recipient. Enter Yes or No.

Passport MD--Enter Passport physician name from Medicaid card.

MD Phone--Enter attending/Passport physician phone number.

Provider Identifying Information--Complete the provider identifying information.

Primary Insurance--If the recipient has a third party payor, identify the private carrier. Third parties pay before Medicaid.

Denial from Primary Insurance--If the recipient has a third party payor and they have denied coverage for services, explain in detail and provide a copy of the explanation of benefits.

Dually Eligible--If the recipient is eligible for Medicare, explain why the claim is being passed to Medicaid. Provide appropriate detail. Medicare benefits must be examined prior to passing the claim to Medicaid.

Type of Prior Authorization Requested--Check the appropriate line. Provide the number of visits if requesting home health aide services.

Synopsis of Services--Explain why the recipient requires services including frequency and duration of such services. Provide outcome goals based upon the authorization of additional services.

## SECTION:

APPENDIX

## SUBJECT:

Request for Initial Authorization  
(DPHHS-SLTC-124)

After signing the form, fax it and any necessary attachments to the Mountain Pacific Quality Health Foundation. Allow ample time for the Foundation to review your request as initial authorizations have only a five day grace period.

o o o

**HOME HEALTH SERVICES  
REQUEST FOR INITIAL AUTHORIZATION**

Recipient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ County \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Is this recipient under Passport? \_\_\_\_\_ Passport MD: \_\_\_\_\_ MD Phone: \_\_\_\_\_

Requesting Agency: \_\_\_\_\_ Contact: \_\_\_\_\_

Provider Number: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Date services to be initiated: \_\_\_\_\_

Does the recipient have primary insurance coverage: \_\_\_\_\_

Has service been denied from primary insurer (provide copy): \_\_\_\_\_

If dually eligible, in detail explain why recipient does not qualify for the Medicare benefit: \_\_\_\_\_

Type of prior authorization requested (July to June):

- \_\_\_\_\_ To provide 1 - 75 skilled nursing visits per state fiscal year.
- \_\_\_\_\_ To provide 1 - 100 combined therapy (PT, ST, OT) visits per state fiscal year.
- \_\_\_\_\_ To provide \_\_\_\_\_ home health aide visits.

Synopsis of services (includes frequency, duration and anticipated outcome):

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

**FOUNDATION USE ONLY**

Approved \_\_\_\_\_ Denied \_\_\_\_\_

Comments:

Reviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: If services in excess of above limits are required, prior authorization must be requested from the Mountain Pacific Quality Health Foundation on form DPHHS-SLTC-125, Request for Prior Authorization for Extended Services.

Fax all Home Health requests to: 1-800-413-3890



Department of Public Health and Human Services	SECTION:  APPENDIX
HOME HEALTH SERVICES	SUBJECT:  Serious Occurrence Report (DPHHS-MA-129)

PURPOSE: Many of the recipients of our services are vulnerable to all sorts of abuse, accidents or neglect. Medicaid providers of home health, personal assistance services, self-direct personal assistance services, hospice, and Home and Community Based Waiver services are required to report in writing, all serious occurrences to their Regional Program Officer (RPO). The Department utilizes a Serious Occurrence Report (SOR) for that purpose. A SOR must be completed anytime an individual's life, health, or safety have been put at risk.

Circumstances Warranting a SOR--Following is a list of incidents necessitating a Serious Occurrence Report:

- Suspected physical or verbal abuse
- Neglect of the recipient
- Sexual harassment
- Injuries requiring medical intervention
- An unsafe working environment
- Any event which is reported to APS or Law Enforcement

Reporting Responsibilities--All providers are mandated to report incidents that involve recipients or effect the provider agency's ability to deliver services. Providers should report only those incidents pertinent to their specific services.

Provider Type	Responsibility
Personal Assistance Providers	Serious occurrences pertaining to the delivery of personal assistance or self-directed personal assistance services.
Home Health Agencies	Serious occurrences pertaining to the delivery of home health services.

## SECTION:

APPENDIX

## SUBJECT:

Serious Occurrence Report  
(DPHHS-MA-129)

Hospice	Serious occurrences pertaining to the delivery of hospice services.
HCBS Case Management Teams	Serious occurrences pertaining to the delivery of HCBS services, except personal assistance.

If a provider has concerns about another provider, they should report the incident to APS and also inform the RPO.

## PROCESS:

SORs are not optional, they are mandatory. Failure to complete a SOR when the situation warrants one, will result in a performance point sheet.

Utilize the following directions when completing a Serious Occurrence Report.

Program--Indicate which program is involved; i.e. personal assistance, home health, hospice, HCBS (indicate specific service) or self-direct personal assistance

Date--Date report is being completed.

Recipient--Name of Medicaid recipient involved in the serious occurrence.

Reporter--Name of person making report.

Incident--Describe what occurred.

Effect--Describe what resulted, or what you believe results from the incident.

Cause--Describe why you believe it occurred.

Action--How is the cause being addressed. Indicate whether a referral was made to a different program or provider based on the situation.

## SECTION:

APPENDIX

## SUBJECT:

Serious Occurrence Report  
(DPHHS-MA-129)

Resolved--Indicate whether the situation has been resolved or not.

Distribution--Forward all three copies to your RPO. The RPO will review the situation, comment and return the white copy to your agency. The pink copy will be forwarded to the central office for tracking purposes.

o o o

PROGRAM _____		DATE: _____	
RECIPIENT _____		MEDICAID ID # _____	
REPORTER: _____			
PROVIDER	INCIDENT (what occurred):          		
	EFFECT (What resulted from the condition):          		
	CAUSE (Why did it occur):          		
	ACTION: (Address cause):          		
	Resolved:    Yes <input type="checkbox"/> No <input type="checkbox"/> (Forward all copies to Regional Program Officer for completion.)		
	Comments: _____ _____ _____ _____		
DPHHS	<input type="checkbox"/> Reviewed <input type="checkbox"/> Memo <input type="checkbox"/> Training <input type="checkbox"/> Case Conference <input type="checkbox"/> Sanction Regional Program Officer _____ Date: _____		

Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME HEALTH SERVICES

## SUBJECT:

Request for Case Review  
(DPHHS-MA-128)

PURPOSE--Often times providers are seriously concerned about another provider's performance in serving our clients. The Request for Case Review form gives them a vehicle on which to note their concerns and forward them to the state office. Use this form with discretion.

Program--Enter the type of provider you are concerned about, i.e., personal assistance, home health, HCBS, etc.

Date--Enter the date on which you are completing the form.

Recipient--If your concern surrounds a single recipient, fill in the individual's name.

Medicaid ID--Enter the recipient's Medicaid ID number.

Reporter--Enter your name and agency. This field is optional.

PROVIDER:

Describe what is happening--Give specific examples with dates and times whenever possible. (For example, worker left 30 minutes early Wed July 21 and Friday July 23 without explanation; or on June 3 client complained that nurse is not changing dressing as indicated in his POC).

Services in place--If your concern is for a specific individual, indicate all the services the recipient is receiving. Otherwise write N/A.

Concern--Clearly state your concern. This means what could result from what is happening. Such as, individual not receiving allocated hours. Individual's health is at risk because wound is not being cared for properly.

## SECTION:

APPENDIX

## SUBJECT:

Request for Case Review  
(DPHHS-MA-128)

Resolved--If you have contacted the agency and have been able to resolve this issue, check the yes box. If not, check the no box.

Forward all copies to the Senior and Long Term Care Division to the attention of the program manager responsible for the service you are concerned about. (Refer to HH 802.)

DPHHS

The program manager will complete this section.

o o o

## REQUEST FOR CASE REVIEW

PROGRAM _____		DATE: _____	
RECIPIENT _____		MEDICAID ID # _____	
REPORTER (Optional): _____			
PROVIDER	Describe what is happening:		
PROVIDER	Services in Place:		
PROVIDER	Concern :		
PROVIDER	Resolved:            Yes <input type="checkbox"/> No <input type="checkbox"/>		
	(Forward all copies to Senior & Long Term Care, DPHHS, PO Box 4210, Helena, MT 59604 for completion.)		
DPHHS	BUREAU ACTION:		
	Cause: _____		
	_____		
	_____		
DPHHS	Resolution: _____		
	_____		
	_____		
	_____		
DPHHS	Adult Protective Services    Yes <input type="checkbox"/> No <input type="checkbox"/>		
	_____		
	_____		
	_____		



Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME HEALTH SERVICES

## SUBJECT:

Quarterly Utilization Report

PURPOSE: To assist the Department in budgeting and forecasting to insure the financial viability of the program.

FREQUENCY: This report must be filed on a quarterly basis, the schedule is as follows:

Q1	July 1 - September 30	Due: October 31
Q2	October 1 - December 31	Due: January 31
Q3	January 1 - March 30	Due: April 30
Q4	April 1 - June 30	Due: July 31

On occasion, the Department may request reports be submitted earlier.

SUBMISSION: Submit Reports to:

Medicaid Home Health Program  
Senior & Long Term Care Division  
PO Box 4210  
Helena MT 59604

## INSTRUCTIONS:

Client Count:

Provide an accurate count of consumers receiving Medicaid Home Health Services on the first (a) and last (b) day of the month for each month of the quarter. Determine the net Change (b-a) in client count for each month.

## EXAMPLE:

	Month 1	Month 2	Month 3
First Day (a)	35	38	37
Last Day (b)	38	37	40
Net Change (b-a)	+3	-1	+3

SECTION:

APPENDIX

SUBJECT:

Quarterly Utilization Report

## Utilization of services:

Complete the following table by providing an accurate number of units of service delivered during each month of the quarter. Enter "0" if you did not provide that particular service.

Then multiply by unit rate to obtain cost by service type, record in column (2). Total column (2) and record in the box (3) below.

## EXAMPLE:

	Month 1	Month 2	Month 3	Totals (1)	Unit	Cost (2)
421 - Physical Therapy	5	2	0	7	\$62.56	\$437.92
431 - Occupational Therapy	0	1	0	1	\$62.56	\$62.56
441 - Speech Therapy	0	0	2	2	\$62.56	\$125.12
551 - Skilled Nursing	45	28	50	123	\$62.56	\$7694.88
517 - Home Health Aide	0	0	0	0	\$27.93	\$0
Total Cost for Services						\$8320.48

All agencies participating in the Montana Medicaid program must file this report. This includes reporting zero if necessary. Failure to file can result in the suspension of claims until the information is received.

A copy of the Quarterly Utilization Report is on page 4. Copy the report from the manual as the Department does not supply this report.

o o o

(Rev. 1/01)

STATE OF MONTANA  
Department of Public Health and Human Services**MEDICAID HOME HEALTH SERVICES  
QUARTERLY UTILIZATION REPORT**

AGENCY: \_\_\_\_\_ PROVIDER ID#: \_\_\_\_\_

CONTACT PERSON (PLEASE PRINT) \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE REPORT IS COMPLETED: \_\_\_\_\_

**For the period of:**  
(circle one)

Q1 July - September

Q2 October - December

Q3 January - March

Q4 April - June

**Client Count:**Please provide an accurate count of consumers receiving **Medicaid** Home Health Services on the first (a) and last (b) day of the month for each month of the quarter. Determine the net change (b-a) in client count for each month.

	Month 1	Month 2	Month 3
First Day (a)			
Last Day (b)			
Net Change (b-a)			

**Utilization of services:**

Complete the following table by providing an accurate number of visits per service delivered during each month of the quarter.

Total Month 1, 2 &amp; 3 and place in column (1). Then multiply by unit rate to obtain cost by service type, record in column (2). Total Column (2) and record in the box (3) below.

	Month 1	Month 2	Month 3	Totals (1)	Unit	Cost (2)
421 - Physical Therapy					\$62.56	
431 - Occupational Therapy					\$62.56	
441 - Speech Therapy					\$62.56	
551 - Skilled Nursing					\$62.56	
517 - Home Health Aide					\$27.93	
Total Cost for Services						(3)



Department of Public Health  
and Human Services

## SECTION:

## APPENDIX

HOME HEALTH SERVICES

## SUBJECT:

Request for Prior Authorization  
for Extended Services  
(DPHHS-SLTC-124)

## DIRECTIONS:

Recipient Identifying Information--Complete the recipient identifying information.

Is this recipient under Passport?--Check the recipient's Medicaid card to determine if they are a PASSPORT recipient. Enter Yes or No.

Passport MD--Enter Passport physician name from Medicaid card.

MD Phone--Enter attending/Passport physician phone number.

Provider Identifying Information--Complete the provider identifying information.

Date Services were Initiated--Enter date when services were originally initiated during the current fiscal year.

Original PA #--Enter the ten digit prior authorization number that was assigned at initial authorization. The reviewer needs this number to amend for any additional visits granted.

Type of Prior Authorization Requested--Indicate which service is needed by checking the appropriate line and providing year-to-date visit totals and the additional visits requested.

Synopsis of Services--Explain why the recipient requires services including frequency and duration of such services. Provide outcome goals based upon the authorization of additional services.

## SECTION:

APPENDIX

## SUBJECT:

Request for Prior Authorization  
for Extended Services  
(DPHHS-SLTC-124)

After signing the form, fax it and any necessary attachments to the Mountain Pacific Quality Health Foundation. Allow ample time for the Foundation to review your request as prior authorizations for extended services are NOT backdated.

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STATE OF MONTANA  
Department of Public Health and Human Services

**HOME HEALTH SERVICES  
REQUEST FOR PRIOR AUTHORIZATION  
FOR EXTENDED SERVICES**

Recipient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ County \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Is this recipient under Passport? \_\_\_\_\_ Passport MD: \_\_\_\_\_ MD Phone: \_\_\_\_\_

Requesting Agency: \_\_\_\_\_ Contact: \_\_\_\_\_

Provider Number: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Date services were initiated \_\_\_\_\_ Original PA # \_\_\_\_\_

Type of prior authorization requested:

\_\_\_\_\_ To provide additional skilled nursing visits. Year-to-date \_\_\_\_\_ Additional requested \_\_\_\_\_

\_\_\_\_\_ To provide additional therapy visits. Year-to-date \_\_\_\_\_ Additional requested \_\_\_\_\_

Type of service	OT	PT	ST
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

\_\_\_\_\_ To provide additional aide visits \_\_\_\_\_

Synopsis of services (includes frequency, duration and anticipated outcome):

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

**FOUNDATION USE ONLY**

\_\_\_\_\_ Approved \_\_\_\_\_ Denied

\_\_\_\_\_ Comments:

Reviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Instructions: Agency: Complete form in full, indicating total number of additional visits being requested.  
Fax all Home Health requests to: 1-800-413-3890.



Department of Public Health  
and Human Services

HOME HEALTH SERVICES

SECTION:

APPENDIX

SUBJECT:

Forms Requisition

The provider agency is required to use the following Department forms in providing home health services.

<u>FORM NUMBER</u>	<u>FORM NAME</u>
DPHHS-SLTC-124	Home Health Services Request for Initial Authorization
DPHHS-SLTC-125	Home Health Services Request for Extended Authorization
DPHHS-MA-128	Request for Case Review
DPHHS-MA-129	Serious Occurences

INSTRUCTIONS: Copy DPHHS-SLTC-124 from section HH 902 and DPHHS-SLTC-125 from section HH 906.

For DPHHS-MA-128 and DPHHS-129, the provider agency fills in the quantity of forms needed for a six month period and sends the forms requisition (page 2) to the Department.

All forms come in bundles of 50 but can be requested in smaller quantities. Please **DO NOT** put down number of bundles, use total number of forms. For example: 100 not 2; 250 not 5.

o o o

HOME HEALTH SERVICES  
FORMS REQUISITION

Send to: Anne McKenzie  
 Senior & Long Term Care  
 DPHHS  
 P.O. Box 4210  
 Helena, MT 59604-4210  
 Phone: 406-444-4077  
 FAX: 406-444-7743

Location Code:

675

Requesting Office Name:		Request Date:
Street Address:	City: Zip:	Telephone No:
Signature of Requestor:		Date Shipped:

Quantity Requested	Quantity Sent	Form Number	Form Name
--------------------	---------------	-------------	-----------

\_\_\_\_\_ MA-128 ..... Request for Case Review (New 4/99)

\_\_\_\_\_ MA-129 ..... Serious Occurences (New 3/99)

NOTE: All forms come in bundles of 50 but can be requested in smaller quantities. Please do not put down number of bundles, use total number of forms. For example: 100 not 2. If you do not receive the forms you ordered, please call the above phone number.





Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME HEALTH SERVICES

## SUBJECT:

Provider Requirement Rules

GENERAL MEDICAID SERVICES

37.85.401

## Subchapter 4

## Provider Requirements

37.85.401 PROVIDER PARTICIPATION (1) As a condition of participation in the Montana medicaid program all providers must comply with all applicable state and federal statutes, rules and regulations, including but not limited to federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the medicaid program and all applicable Montana statutes and rules governing licensure and certification. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

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ADMINISTRATIVE RULES OF MONTANA

3/31/00

37-19501

Nov. 1, 2001

SENIOR &amp; LONG TERM CARE

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## SECTION:

APPENDIX

## SUBJECT:

Provider Requirement Rules

## GENERAL MEDICAID SERVICES

37.85.402

37.85.402 PROVIDER ENROLLMENT AND AGREEMENTS

(1) Providers must enroll in the Montana medicaid program for each category of services to be provided. As a condition of granting enrollment approval or of allowing continuing enrollment, the department may require the provider to:

- (a) complete and submit an enrollment application or form;
- (b) complete and submit agreements or other forms applicable to the provider's category of service;
- (c) provide information and documentation regarding ownership and control of the provider entity and regarding the provider's ownership interest or control rights in other providers that bill medicaid;
- (d) provide information and documentation regarding:
  - (i) any sanctions, suspensions, exclusions or civil monetary penalties imposed by the medicare program, any state medicaid program or other federal program against the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider; and
  - (ii) any criminal charges brought against and any criminal convictions of the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider related to that person's or entity's involvement in medicare, medicaid or the Title XX services program; and

(e) submit documentation and information demonstrating compliance with participation requirements applicable to the provider's category of service.

(2) Providers shall provide the department's fiscal agent with 30 days advance written notice of any change in the provider's name, address, tax identification number, group practice arrangement, business organization or ownership.

(a) An enrolled provider is not entitled to change retroactively the category of service for which the provider is enrolled, but must enroll prospectively in the new program category. The change in service category will be effective only upon approval of a completed enrollment application for the new service category and on or after the effective date of all required licenses and certifications. The change will apply only to services provided on or after the effective date of the enrollment change.

(3) Except as provided in (2)(a), an approved enrollment is effective on the later of:

- (a) 1 year prior to the date the completed enrollment application is received by the department's fiscal agent; or
- (b) the date as of which all required licenses and certifications are effective.

## SECTION:

## APPENDIX

## SUBJECT:

## Provider Requirement Rules

37.85.402

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

(4) Providers, whose services are covered by the Title XVIII program (medicare), shall meet the certification standards of medicare except as provided otherwise in these rules.

(5) Providers shall render services to an eligible medicaid recipient in the same scope, quality, duration and method of delivery as to the general public, unless specifically limited by these regulations.

(a) No provider may deny services to any recipient because of the recipient's inability to pay a copayment in ARM 37.83.826 or in ARM 37.85.204.

(6) Providers shall not discriminate illegally in the provision of service to eligible medicaid recipients or in employment of persons on the grounds of race, creed, religion, color, sex, national origin, political ideas, marital status, age or disability. Providers shall comply with the Civil Rights Act of 1964 (42 USC 2000d, et seq.), The Age Discrimination Act of 1975 (42 USC 6101, et seq.), The Americans With Disabilities Act of 1990 (42 USC 12101, et seq.), section 504 of the Rehabilitation Act of 1973 (29 USC 794), and the applicable provisions of Title 49, MCA, as amended and all regulations and rules implementing the statutes. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1987 MAR p. 900, Eff. 6/30/87; AMD, 1987 MAR p. 1116, Eff. 7/17/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

Rules 03 through 05 reserved

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37-19504

3/31/00

ADMINISTRATIVE RULES OF MONTANA

## SECTION:

APPENDIX

## SUBJECT:

Provider Requirement Rules

## GENERAL MEDICAID SERVICES

37.85.406

37.85.406 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT (1) Providers must submit clean claims to medicaid within the latest of:

- (a) 12 months from the latest of:
  - (i) the date of service;
  - (ii) the date retroactive eligibility is determined; or
  - (iii) the date disability was determined;
- (b) 6 months from the date on the medicare explanation of benefits approving the service, if the medicare claim was timely filed and the recipient was medicare eligible at the time the medicare claim was filed; or
- (c) 6 months from the date on an adjustment notice from a third party payor, where the third party payor has previously processed the claim for the same service and the adjustment notice is dated after the periods described in (1) (a) and (b).

(2) For purposes of this section:

(a) "Clean claim" means a claim that can be processed without additional information or documentation from or action by the provider of the service;

(b) For inpatient hospital services, date of service is the date of discharge;

(c) The date of submission to the medicaid program is the date the claim is stamped "received" by the department or its designee; and

(d) The claim submission deadline specified in (1) applies regardless of whether or not a third party has allowed or denied a provider's claim. If a third party has not allowed or denied a provider's claim, the provider may submit a claim to medicaid according to the requirements of ARM 37.85.407(6)(c) and subject to the claim submission deadline specified in (1).

(3) Claims must be submitted in accordance with this rule to be valid. In processing claims, the department or its agent may deny payment of or pend a claim upon determining that a basis exists for denial of payment or pending the claim. No further review or processing of a denied claim is required until resubmission of the claim by the provider. The department or its agent is not required to list or identify all possible grounds for denial or pending of the claim. The fact that a particular basis for denial or pending of a claim for a service or item was not identified on an earlier statement of remittance or other similar statement does not preclude denial or pending of the claim on that basis on a later submission of the claim.

## SECTION:

## APPENDIX

## SUBJECT:

## Provider Requirement Rules

37.85.406

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

(4) Except as provided in (7) of this rule, all medicaid claims submitted to the department are to be submitted on a state claim form which is:

- (a) personally signed by that provider;
- (b) personally signed by a person who has actual written authority to bind and represent the provider for this purpose. The department may require a provider to furnish this written authorization; or
- (c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer generated, typed or block letter signature shall bear full responsibility for submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.

(5) All medicaid claims submitted to the department by a hospital for services provided by a physician who is required to relinquish fees to the hospital are to be submitted on a state claim form which is:

- (a) personally signed by the physician provider;
- (b) personally signed by a person who has actual written authority to bind and represent the physician provider for this purpose. The department may require a provider to furnish this written authorization; or
- (c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer-generated, typed or block letter signature shall bear full responsibility for submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.

(6) The department may require a hospital provider to obtain on the claim form the signature of a physician providing services for which fees are relinquished to the hospital.

(7) Electronic media claims may be submitted by a provider who enters into an agreement with the department for this purpose and who meets the department's requirements for documentation, record retention and signature requirements.

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## GENERAL MEDICAID SERVICES

37.85.406

(8) Claims submitted for the professional component of electrodiagnostic procedures which do not involve direct personal care on the part of the physician and performed by physicians on contract to the hospital may be submitted on state approved claim forms signed by the person with authority to bind the hospital under (b) above.

(a) Electrodiagnostic procedures include echocardiology studies, electroencephalography studies, electrocardiology studies, evoked potential studies, holter monitors, telephonic or teletrace checks and pulmonary function tests.

(b) If, after review, the department determines that claims for hospital-based physician services are not submitted by a hospital provider in accordance with this subsection, the department may require the hospital provider to obtain the signature of the physician providing the service on the claim form.

(9) If the department pays a claim but subsequently discovers that the provider was not entitled to payment for any reason, the department is entitled to recover the resulting overpayment as provided in (10).

(10) The department is entitled to recover from the provider and the provider is obligated to repay to the department all medicaid payments made to which the provider was not entitled under applicable state and federal laws, regulations and rules. At the option of the department, recoveries may be accomplished by a direct payment to the department or by automatic deductions from future payments due the provider. Notice of overpayment must be made in accordance with ARM 37.85.512.

(a) The department is entitled to recover under (10) any payment to which the provider was not entitled, regardless of whether the payment was the result of department or provider error, or other cause, and without proving that the provider submitted an improper or erroneous claim knowingly, intentionally, or with intent to defraud.

(b) The department is entitled to recover an overpayment from the provider in whose name the erroneous or improper claim was submitted, even if the provider was an employee of another individual or entity and was required as a condition of the provider's employment to turn over all fees received by the provider to the employer.

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(11) Providers are required to accept, as payment in full, the amount paid by the Montana medicaid program for a service or item provided to an eligible medicaid recipient in accordance with the rules of the department. Providers shall not seek any payment in addition to or in lieu of the amount paid by the Montana medicaid program from a recipient or his representative, except as provided in these rules. A provider may bill a recipient for the copayments specified in ARM 37.83.826 and 37.85.204 and may bill certain recipients for amounts above the medicare deductibles and coinsurance as allowed in ARM 37.83.825.

(a) A provider may bill a recipient for noncovered services if the provider has informed the recipient in advance of providing the services that medicaid will not cover the services and that the recipient will be required to pay privately for the services, and if the recipient has agreed to pay privately for the services. For purposes of (11)(a), non-covered services are services that may not be reimbursed for the particular recipient by the Montana medicaid program under any circumstances and covered services are services that may be reimbursed by the Montana medicaid program for the particular recipient if all applicable requirements, including medical necessity, are met.

(b) Except as provided in this rule, a provider may not bill a recipient after medicaid has denied payment for covered services because the services are not medically necessary for the recipient.

(i) A provider may bill a recipient for covered but medically unnecessary services, including services for which medicaid has denied payment for lack of medical necessity, if the provider specifically informed the recipient in advance of providing the services that the services are not considered medically necessary under medicaid criteria, that medicaid will not pay for the services and that the recipient will be required to pay privately for the services, and the recipient has agreed to pay privately for the services. The agreement to pay privately must be based upon definite and specific information given by the provider to the recipient indicating that the service will not be paid by medicaid. The provider may not bill the recipient under this exception when the provider has informed the recipient only that medicaid may not pay or where the agreement is contained in a form that the provider routinely requires recipients to sign.

(ii) An ambulance service provider may bill a recipient after medicaid has denied payment for lack of medical necessity.

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37.85.406

(c) A provider may not bill a recipient for services as a private pay patient if, prior to provision of the services, the recipient informed the provider of medicaid eligibility, unless, prior to provision of the services, the provider informed the recipient of its refusal to accept medicaid and the recipient agreed to pay privately for the services.

(d) In service settings where the recipient is admitted or accepted as a medicaid recipient by a provider, facility, institution or other entity that arranges provision of services by other or ancillary providers, all other or ancillary providers will be deemed to have accepted the individual as a medicaid recipient and may not bill the recipient for the services unless, prior to provision of services, the particular provider informed the recipient of its refusal to accept medicaid and the recipient agreed to pay privately for the services.

(e) The provider may not bill a recipient for services when medicaid does not pay as a result of the provider's failure to comply with applicable enrollment, prior authorization, billing or other requirements necessary to obtain payment.

(f) Acceptance of a recipient as a medicaid recipient applies to all services provided by the provider to the recipient, except as provided in (11)(a) or (b). A provider may not accept medicaid payment for some covered services but refuse to accept medicaid for other covered services. Subject to the requirements of ARM 37.85.402(4), a provider may terminate acceptance of medicaid for a recipient in accordance with the provider's professional responsibility, by informing the recipient of the termination and the effect of the termination on provision of and payment for any further services.

(g) If an individual has agreed prior to receipt of services that payment will be made from a source other than medicaid but later is determined retroactively eligible for medicaid, the provider may choose to accept the individual as a medicaid recipient with respect to the services or to seek payment in accordance with the original payment agreement.

(h) A provider that bills medicaid for services rendered will be deemed to have accepted the individual as a medicaid recipient.

(i) Nothing in this rule is intended to permit a provider to refuse to accept an individual as a medicaid recipient where the provider is otherwise required by law to accept an individual as a medicaid recipient.

(12) In the event that a provider of services is entitled to a retroactive increase of payment for services rendered, the provider shall submit a claim within 180 days of the written notification of the retroactive increase or the provider forfeits any rights to the retroactive increase.

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(13) The Montana medicaid program shall make payments directly to the individual provider of service unless the individual provider is required, as a condition of his employment, to turn his fees over to his employer.

(a) Exceptions to the above requirement may, at the discretion of the department, be made for transportation and/or per diem costs incurred to enable a recipient to obtain medically appropriate services.

(14) The method of determining payment rates for out-of-state providers will be the same as for in-state providers except as otherwise provided in the rules of the department.

(15) A government agency may bill the medicaid program for covered medical services under the following circumstances:

(a) The government agency has complied with all federal and state law governing the medicaid program, and assures that the provider has complied with all state and federal law governing the medicaid program, including reimbursement levels.

(b) The government agency accepts assignment from an eligible medicaid provider for services provided prior to eligibility determination.

(16) A person enrolled as an individual provider may not submit a claim for services that the provider did not personally provide, inclusive of services provided by another person under the provider's supervision, unless authorization to bill for and receive reimbursement for services the provider did not personally provide is stated in administrative rule or a Montana medicaid program manual and is in compliance with any supervision requirements in state law or rule governing the provider's professional practice and the practice of assistants and aides. Other providers, including but not limited to hospitals, nursing facilities and home health agencies, may bill for and receive reimbursement for services provided by supervised persons in accordance with the medicaid rules and manual and any supervision requirements in state law or rule governing professional practice.

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(17) Medicaid coverage and reimbursement is available only for services or items that are provided in accordance with all applicable medicaid requirements and within the scope of practice permitted under state licensure laws and other mandatory standards applicable to the provider. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1981 MAR p. 530, Eff. 5/29/81; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 771, Eff. 7/31/81; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1986 MAR p. 359, Eff. 3/14/86; AMD, 1987 MAR p. 894, Eff. 6/26/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1990 MAR p. 379, Eff. 2/23/90; AMD, 1990 MAR p. 1586, Eff. 8/17/90; AMD, 1992 MAR p. 234, Eff. 2/14/92; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; AMD, 1998 MAR p. 2168, Eff. 8/14/98; TRANS, from SRS, 2000 MAR p. 479.)

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## GENERAL MEDICAID SERVICES

37.85.407

37.85.407 THIRD PARTY LIABILITY (1) No payment shall be made by the department for any medical service for which there is a known third party who has a legal liability to pay for that medical service except for those services specified in (6) below.

(2) For purposes of this section, the following definitions apply:

(a) A third party is defined as an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the cost of medical treatment and medical-related services for personal injury, disease, illness, or disability of a recipient of medical assistance from the department or a county and includes but is not limited to insurers, health service organizations, and parties liable or who may be liable in tort. Indian health services is not a third party within the meaning of this definition.

(b) A known third party is a third party for which the provider has sufficient information to submit a claim and which if billed for a medical service is likely to pay the claim within a reasonable time.

(c) A potential third party is a third party for which the provider either has insufficient information to submit a claim or which if billed for a medical service, is likely to deny the claim as having no contractual or legal obligation to pay.

(3) For known recipients, the provider shall use its same usual and customary procedures for inquiring about possible third party resources as is done for non-recipients.

(4) If the provider delivers to a recipient or a recipient's legal representative a copy of a billing statement for services which have been or may be billed to the department, the statement must clearly indicate that third party benefits or payments have been assigned to the department by the patient or that the department may have a lien upon such benefits.

(a) The words "medicaid has assignment of, or may have a lien upon third party benefits or payments" shall be sufficient to meet the notification requirement of this section.

(b) If a provider does not meet the notification requirements of this section, the department may withhold or recover from the provider an amount equal to any amounts paid by a third party towards the services described in the statement given to the recipient.

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(5) If a provider learns of the existence of a known third party, that provider shall bill the third party prior to billing the department. If the department has knowledge of a known third party and the provider has not complied with (6) or (7) below, the department shall deny payment of the services.

(6) The department shall not deny payment of services solely because of the existence of a third party in the following circumstances:

(a) The primary diagnosis on the claim is for certain prenatal and preventive pediatric care as specified in the medicaid provider manual, copies of which may be obtained from the Montana Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The provider may bill the third party or the department in this circumstance.

(b) The third party is an insurer under a health insurance policy provided by the absent parent of a recipient and that health insurance is obtained or maintained as a result of an enforcement action taken by the child support enforcement division against that absent parent, if the following provisions are met:

(i) the provider submits evidence that the third party has been billed;  
(ii) the claim is submitted to the department 30 or more days beyond the date of service and in compliance with the timely filing rules in ARM 37.85.406(1);

(iii) the provider certifies on the claim that notice of payment or denial of the claim has not been received from the third party; and

(iv) the claim is submitted directly to the third party liability unit (hereafter referred to as the TPL unit) within the department.

(c) The provider has billed the third party and has not received a reply from the third party either allowing or denying payment, if the following provisions are met:

(i) the provider submits evidence of the date the third party was billed;  
(ii) the claim is submitted 90 or more days beyond the date established in (c)(i) and in compliance with the timely filing rules in ARM 37.85.406(1);  
(iii) the provider certifies on the claim that notice of payment or denial has not been received; and

(iv) the provider submits the claim directly to the TPL unit.

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(d) The claim is for services for which the department has been granted a waiver from use of the cost avoidance method and the department has chosen to use and continue to use that waiver, as identified in the medicaid provider manual.

(e) The provider is unable to obtain a valid assignment of benefits, if the following provisions are met:

(i) the provider submits documentation that it attempted to obtain assignment;

(ii) the provider certifies on the claim that assignment could not be obtained; and

(iii) the provider submits the claim directly to the TPL unit.

(f) The third party is only a potential third party as defined in (2)(c).

(7) Except as stated in (8), the department shall pay its allowed amount for services, less any known third party payments for those services, for any claim where a known third party exists in the following circumstances:

(a) the claim is submitted under the provisions of (6);

(b) the submitted claim clearly indicates the amount paid by the third party and includes whatever documentation is received regarding the payment from the third party; or

(c) the claim is submitted with a denial document which clearly shows that the third party denied the claim.

(8) For inpatient hospital claims where medicare Part A benefits have been paid, the department's sole obligation shall be to pay the medicare Part A deductible. For nursing facility service claims where medicare Part A benefits have been paid, the department's sole obligation shall be to pay in accordance with ARM 37.40.307.

(9) In the event the provider receives a payment from a third party after the department has made payment, the provider shall refund to the department, within 60 days of receipt of the third party payment, the lesser of the amount the department paid or the amount of the third party payment.

(a) The refund shall be made payable to Montana medicaid and submitted to the department's fiscal office, and shall indicate the name of the third party payor.

(b) The provider is entitled to retain any third party payments which exceed the medicaid allowed amount if all medicaid payments toward those services have been refunded to the department as required in this subsection.

(10) The department shall make no payment for services in those cases where, if the patient were not a medicaid recipient, the third party payment would constitute full payment with no further obligation owing from the recipient.

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(11) For any service where an identified third party has only a potential liability as a tort-feasor, the provider may file a medical lien against that third party. The provider may bill the department prior to determination of liability of the third party if the provider notifies the TPL unit of the identity of the third party and its name and address if known. The provider may keep its lien in place and receive payment from the third party. If payment is received from the third party, the provider must refund to the department as described in (9).

(12) A provider may not refuse to furnish services to a recipient based upon a third party's potential liability for the service. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1984 MAR p. 1637, Eff. 11/16/84; AMD, 1990 MAR p. 1719, Eff. 8/31/90; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

Rules 08 and 09 reserved

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## GENERAL MEDICAID SERVICES

37.85.410

37.85.410 DETERMINATION OF MEDICAL NECESSITY (1) The department shall only make payment for those services which are medically necessary as determined by the department or by the designated review organization.

(2) In determining medical necessity the department or designated review organization may consider the type or nature of the service, the provider of the service, the setting in which the service is provided and any additional requirements applicable to the specific service or category of service.

(3) The department may review the medical necessity of services or items at any time either before or after payment. If the department determines that services or items were not medically necessary or otherwise in compliance with applicable requirements, the department may deny payment or may recover any overpayment in accordance with applicable requirements. The department is not precluded by an earlier screening, prior authorization, certification or similar process from reviewing and determining medical necessity of any service or item, or from denying payment or recovering any overpayment based upon any such review or determination. This rule does not require the department to notify a provider or recipient of a medical necessity determination until and unless the department completes its review and takes an adverse action against the provider based upon the determination.

(4) The provider must upon request provide to the department or its designated review organization without charge any records related to services or items provided to a recipient. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

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Provider Requirement Rules

37.85.411

DEPARTMENT OF PUBLIC HEALTH  
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37.85.411 PROVIDER RIGHTS (1) Except as otherwise provided in these rules, a provider who is aggrieved by an adverse department action which directly affects the rights or entitlements of the provider under the Montana medicaid program, may request a hearing to the extent provided and according to the procedures specified in ARM 37.5.304, 37.5.305, 37.5.307 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(2) Except as otherwise provided in these rules, a provider who is aggrieved by an adverse department action affecting the applicant's or recipient's eligibility under the Montana medicaid program, may request a hearing to the extent provided and according to the procedures specified in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(3) This rule does not grant to providers any right to notice of actions affecting recipients, including but not limited to eligibility determinations. (History: Sec. 2-4-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

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## SUBJECT:

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## GENERAL MEDICAID SERVICES

37.85.414

37.85.414 MAINTENANCE OF RECORDS AND AUDITING (1) All providers of service must maintain records which fully demonstrate the extent, nature and medical necessity of services and items provided to Montana medicaid recipients which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. These records must be retained for a period of at least 6 years and 3 months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later.

(a) In maintaining financial records, providers shall employ generally accepted accounting methods. Generally accepted accounting methods are those approved by the national association of certified public accountants.

(b) The department shall have access to all records so maintained and retained regardless of a provider's continued participation in the program.

(c) In the event of a change of ownership, the original owner must retain all required records unless an alternative method of providing for the retention of records has been established in writing and approved by the department.

(2) In addition to the recipient's medical records, any medicaid information regarding a recipient or applicant is confidential and shall be used solely for purposes related to the administration of the Montana medicaid program. This information shall not be divulged by the provider or his employees, to any person, group, or organization other than those listed below or a department representative without the written consent of the recipient or applicant.

(3) The department, the designated review organization, the legislative auditor, the department of public health and human services, the department of revenue, the medicaid fraud control unit, and their legal representatives shall have the right to inspect or evaluate the quality, appropriateness, and timeliness of services performed by providers, and to inspect and audit all records required by this rule.

(a) Refusal to permit inspection, evaluation or audit of services shall result in the imposition of provider sanctions in accordance with the rules of the department.

(4) The provisions of this rule specifying the length of time for which records must be retained shall not be construed as a limitation on the period in which the department may recover overpayments or impose sanctions. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

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37.85.415

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES37.85.415 MEDICAL ASSISTANCE MEDICAID PAYMENT

- (1) Medicaid will pay only for medical expenses:
  - (a) incurred by a person eligible for the medicaid program;
  - (b) for services provided for and to the extent provided for under the medicaid program;
  - (c) for which third party payment is not available;
  - (d) not used to meet the incurrment requirement at ARM 37.82.1101 and following rules for persons who are medically needy;
  - (e) which are not the copayment provided for in ARM 37.85.204; and
  - (f) to the extent allowed by medicaid. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 479.)

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## GENERAL MEDICAID SERVICES

37.85.416

37.85.416 STATISTICAL SAMPLING AUDITS (1) At the option of the department, the amount of money erroneously paid to a provider for any given period of time may be determined by the use of statistical sampling and extrapolation, rather than by an audit of 100% of the claims submitted by the provider during the period of time under review. Statistical sampling and extrapolation shall not be used to determine overpayments for inpatient hospital services, outpatient hospital services, or hospital inpatient psychiatric services, or in cases where the number of line items in the review period does not equal 500 or more.

(a) A line item consists of a single service, under one procedure rate with one or more units of service, procedure or item on a medicaid claim form for which a provider has received payment.

(2) If the department chooses to use statistical sampling and extrapolation to determine an overpayment, it will use a statistical method to draw a random sample of claims for the review period and will audit these claims. The department will calculate the provider's error rate based on the net dollar amount overpaid to the provider after any underpayments occurring in the sample have been offset against the overpayments occurring in the sample. The department will then calculate the total overpayment for the review period using an appropriate statistical methodology.

(3) If the department chooses to use statistical sampling and extrapolation, it shall notify the provider of its intention to do so. When the sampling and extrapolation process is completed, the department shall provide the provider with information regarding the sample size, the sample selection method, and the formulas and calculations used in the extrapolation.

(4) It is presumed that the overpayment amount determined by the use of statistical sampling and extrapolation is correct. However, the provider may rebut this presumption by presenting evidence that the sampling and extrapolation process used by the department was invalid, by presenting evidence that claims in the sample determined by the department to be erroneous or overpaid were correctly paid, or by requesting an audit of 100% of the claims paid in the review period, as provided in (5).

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(5) A provider who does not agree with the overpayment amount determined by statistical sampling may request that the department conduct a 100% audit of the claims paid in the review period. The request for a 100% audit must be made within 30 days of the date of the notice informing the provider of the results of the statistical sampling. The department must then conduct such a review.

(a) If the audit shows an overpayment amount which is different from the overpayment amount determined by sampling and extrapolation, the amount determined by the audit shall be used by the department in assessing an overpayment against the provider. A provider who is aggrieved by a department determination based upon the results of the audit may appeal by means of the fair hearing procedures set forth in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(b) The provider must pay the department's costs for such an audit, unless the overpayment amount determined by the 100% audit is at least 10% less than the overpayment amount determined by the statistical sample.

(6) A provider who is aggrieved by an overpayment determined by statistical sampling and extrapolation may appeal by means of the fair hearing procedures set forth in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-111, MCA; NEW, 1993 MAR p. 441, Eff. 3/26/93; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

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Department of Public Health  
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## APPENDIX

## HOME HEALTH SERVICES

## SUBJECT:

Home Health Services A-  
dministrative Rules of  
Montana

## Home Health Services

37.40.701 HOME HEALTH SERVICES DEFINITIONS (1) "Home-bound status" means that a recipients:

(a) is confined on a full time, part time or intermittent basis to the person's place of residence for medical reasons;

(b) is unable to obtain required medical services without demonstrated taxing effort; or

(c) cannot reasonably obtain medical services other than through a home health agency.

(2) "Home health aide services" means services to assist a recipient in the activities of daily living and the care of the household.

(3) "Home health services" means services provided by a licensed home health agency to a recipient considered homebound in the recipient's place of residence for the purposes of postponing or preventing institutionalization.

(a) Home health services include:

(i) skilled nursing services;

(ii) home health aide services;

(iii) physical therapy services;

(iv) occupational therapy services;

(v) speech therapy services; and

(vi) medical supplies and equipment suitable for use in the home.

(b) Home health services do not include:

(i) personal care services as provided at ARM 37.40.1101 et seq.;

(ii) visits made by a registered nurse for evaluating the home health needs of a recipient or to review the provision of home health services by a home health aide or a licensed practical nurse; and

(iii) maintenance therapy as provided at ARM 37.86.601, et seq.

(4) "Home health service visit" means a personal contact in the place of residence of a recipient made for the purpose of providing a covered home health service.

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Home Health Services Administrative Rules of Montana

37.40.701

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AND HUMAN SERVICES

(5) "Place of residence" means the residential setting in which the recipient generally resides.

(a) Place of residence includes a recipient's own home, a personal care facility, a foster home, a community home or other residential setting for persons who have a developmental disability or a physical disability, a rooming house or a retirement home.

(b) Place of residence does not include a hospital, a nursing facility, an adult day care center, or a day habilitation facility providing developmental disabilities services.

(6) "Skilled nursing services" means nursing services, as defined in the Montana Nurse Practice Act, provided on an intermittent or part time basis to meet the medical needs of a recipient who needs nursing procedures. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1761, Eff. 6/27/80; AMD, 1981 MAR p. 690, Eff. 7/17/81; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2017, Eff. 1/1/87; AMD, 1989 MAR p. 1285, Eff. 9/1/89; AMD, 1995 MAR p. 1182, Eff. 7/1/95; AMD, 1997 MAR p. 1042, Eff. 6/24/97; TRANS, from SRS, 2000 MAR p. 489.)

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ADMINISTRATIVE RULES OF MONTANA

## SECTION:

APPENDIX

## SUBJECT:

Home Health Services Administrative Rules of Montana

## SENIOR AND LONG TERM CARE SERVICES

37.40.702

37.40.702 HOME HEALTH SERVICES, REQUIREMENTS (1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) A home health agency must be:

(a) licensed by the Montana department of public health and human services;

(b) medicare certified; and

(c) an enrolled medicaid provider.

(3) Home health services may be provided by providers located outside of the borders of the state of Montana only if the service meets the requirements of ARM 37.85.207(3) and the service is prior authorized by the department or the department's designee.

(4) Home health services must be:

(a) ordered by the recipient's attending physician;

(b) part of a written plan of care; and

(c) reviewed and renewed by the recipient's attending physician at a minimum of 60 day intervals.

(5) The provider must maintain documentation that the recipient meets the homebound definition.

(6) Written physician orders, care plans and other recipient records must be current and available upon request of the department or its designated representative.

(7) Home health services, except skilled nursing services, are limited to a combined maximum of 100 visits per recipient per fiscal year. Skilled nursing services are limited to 75 visits per recipient per fiscal year.

(a) The department may, within its discretion, authorize additional visits in excess of this limit. Any services exceeding this limit must be prior authorized by the department or the department's designee.

(8) Home health aide services are subject to the following limitations:

(a) Home health aide services must be prior authorized by the department or the department's designee.

(b) Home health aide services must be provided under the supervision of a registered professional nurse and in accordance with a written plan of treatment established by a physician.

(c) A person receiving personal care attendant services may not receive home health aide services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1761, Eff. 6/27/80; AMD, 1986 MAR p. 2017, Eff. 1/1/87; AMD, 1989 MAR p. 1285, Eff. 9/1/89; AMD, 1995 MAR p. 1182, Eff. 7/1/95; AMD, 1997 MAR p. 1042, Eff. 6/24/97; TRANS, from SRS, 2000 MAR p. 489.)

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Home Health Services Administrative Rules of Montana

## SENIOR AND LONG TERM CARE SERVICES

37.40.705

37.40.705 HOME HEALTH SERVICES, REIMBURSEMENT

(1) Reimbursement fees for home health services are as provided for in this rule.

(2) The interim reimbursement for a category of service submitted for reimbursement as provided in (4) or (5) is the most current medicare percent of billed charges for each provider.

(3) The provider's final reimbursement as provided for in (4) and (5) is calculated when the actual reimbursement fees based on the medicare cost settlements are determined for the period. The medicare cost settlements are derived from an audit of allowable costs conducted for medicare purposes.

(4) For home health agencies located within the borders of the state that began providing services before July 1, 1989, the reimbursement fee for a category of service after January 1, 1990 and prior to July 1, 1995 is the lowest of:

- (a) the provider's billed charges;
- (b) the average medicare cost for the category of service;
- (c) the upper medicare limit for the category of service; or
- (d) the adjusted indexed fee for the category of service for state fiscal year ending June 30, 1990.

(i) The state fiscal year 1990 adjusted indexed fee for a category of service is the sum of:

(A) the lowest fee for the category of service reported in the provider's medicaid cost settlement report ending calendar year 1989, indexed to a common fiscal year ending December 30, 1989 by the most recent home health DRI market basket index percentage of the health care financing administration of the department of health and human services (HCFA); and

(B) 2% of the indexed lowest fee. The department hereby adopts and incorporates by reference the HCFA home health DRI market basket rate which is a forecast model of market basket increase factors. The rate and a description of the general methodology and variables used in formulating this model is available from HCFA, Office of the Actuary, 6325 Security Blvd., Baltimore, MD 21209.

(ii) The state fiscal year 1991 indexed fee for a category of service is the 1990 indexed fee for a category of service increased by 2%.

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Home Health Services Administrative Rules of Montana

37.40.705

DEPARTMENT OF PUBLIC HEALTH  
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(5) For home health agencies which are located within the borders of the state that began providing services on or after July 1, 1989, the medicaid reimbursement fee for a category of service delivered prior to July 1, 1995 is the lowest of:

- (a) the provider's billed charges;
- (b) the average medicare cost for the category of service;
- (c) the upper medicare cost limit for the category of service; or
- (d) the adjusted averaged medicaid fee for the category of service for that state fiscal year.

(i) The adjusted averaged medicaid fee for a category of service is the sum of:

(A) costs for the category derived from the most recent medicaid cost settlements finalized before June 30, of that state fiscal year from all participating in-state home health providers divided by the total number of delivered services; and

(B) 2% of the averaged medicaid fee.

(6) For home health agencies located within the borders of the state for services provided on or after July 1, 1995 and prior to July 1, 1997, the reimbursement fee for a home health service, except for a home health aide service, is 60% of the average of the provider's medicare cost limits for skilled nursing, physical therapy, speech therapy and occupational therapy services.

(a) The reimbursement fee for home health aide services is 60% of the provider's medicare cost limit for that service.

(7) For home health services provided on or after July 1, 1997, the reimbursement is the following:

- (a) for a nursing or therapy service - \$59.54 per visit;
- (b) for a home health aide visit - \$26.60;
- (c) for medical supplies and equipment suitable for use in the home - 90% of the amount allowable for the specific item under medicare. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1762, Eff. 6/27/80; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2017, Eff. 1/1/87; AMD, 1989 MAR p. 1285, Eff. 9/1/89; AMD, 1990 MAR p. 1042, Eff. 6/1/90; AMD, 1991 MAR p. 1856, Eff. 9/27/91; AMD, 1995 MAR p. 1182, Eff. 7/1/95; AMD, 1997 MAR p. 1042, Eff. 6/24/97; TRANS, from SRS, 2000 MAR p. 489.)

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Department of Public Health  
and Human Services

## SECTION:

APPENDIX

HOME HEALTH SERVICES

## SUBJECT:

Sanction Rules

GENERAL MEDICAID SERVICES

37.85.501

## Subchapter 5

## Provider Sanctions

37.85.501 GROUNDS FOR SANCTIONING (1) Sanctions may be imposed by the department against a provider of medical assistance, provided under this chapter; Title 37, chapters 40, 80, 82, 83, 85, 86, 88, ARM 37.85.415; ARM 37.83.201 and 37.83.202, and Title 46, chapter 25, for any one or more of the following reasons:

(a) Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

(b) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled under the rules of the department.

(c) Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

(d) Failure to maintain and retain records required by the rules of the department.

(e) Failure to disclose or make available required records to the department, its authorized agent or other legally authorized persons, organizations, or governmental entities.

(f) Failure to provide and maintain services to medicaid recipients at a quality that is within accepted medical community standards as adjudged by a body of peers.

(g) Engaging in a course of conduct or performing an act which the department's rules or the decision of the applicable professional peer review committee, or licensing board, have determined to be improper or abusive of the Montana medicaid program; or continuing such conduct following notification that the conduct should cease.

(h) Breach of the terms of the provider contract or failure to comply with the terms of the provider certification on medical assistance claim forms or the failure to comply with requirements imposed by the rules of the department.

(i) Over-utilizing the Montana medicaid program by inducing, or otherwise causing a recipient to receive services or goods not medically necessary.

(j) Rebating or accepting a fee or portion of a fee or charge for a medicaid patient referral.

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## SUBJECT:

Sanction Rules

37.85.501

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

(k) Violating any provision of the state medicaid law, Title 53, chapter 6, MCA or any rule promulgated pursuant thereto, or violating any provision of Title XIX of the Social Security Act or any regulation promulgated pursuant thereto.

(l) Submission of a false or fraudulent application for provider status.

(m) Violations of any statutes, regulations or code of ethics governing the conduct of occupations or professions or regulated industries.

(n) Conviction of a criminal offense relating to medical assistance programs administered by the department or provided under contract with the state; or conviction for negligent practice resulting in death or injury to patients.

(o) Failure to meet requirements of state or federal law for participation (e.g. licensure).

(p) Exclusion from the medicare program (Title XVIII of the Social Security Act) because of fraudulent or abusive practices.

(q) Charging medicaid recipients for amounts over and above the amounts paid by the department for services rendered, except as specifically allowed under ARM 37.83.825 and 37.83.826.

(r) Refusal to execute a new provider agreement when requested to do so.

(s) Failure to correct deficiencies as defined by the ARM or federal regulation after receiving written notice of these deficiencies from the department, or the federal department of health and human services. The standards set forth at 42 CFR Part 442 and the amendments proposed to this section as published in the federal register, vol. 52, no. 126 on July 1, 1987, at page 24752 et seq. which identify deficiencies for providers of long term care facility services, are hereby incorporated by reference. A copy of 42 CFR Part 442 and the amendments proposed to this section as published in the federal register, vol. 52, no. 126 on July 1, 1987, at page 24752 et seq. are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(t) Formal reprimand or censure by an association of the provider's peers for unethical practices.

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## GENERAL MEDICAID SERVICES

37.85.501

(u) Suspension or termination from participation in another government medical program including but not limited to workers' compensation, crippled children's services, rehabilitation services and medicare.

(v) Filing of criminal indictment, information or complaint for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(w) Civil judgement for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(x) Failure to repay or make acceptable arrangements for the repayment of identified overpayments or otherwise erroneous payments.

(y) Threatening, intimidating or harassing patients or their relatives in an attempt to influence reimbursement rates or affect the outcome of disputes between the provider and the department.

(z) Submitting claims for reimbursement of costs or services which the provider knows or has reason to know are not reimbursable. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-2-803, 53-4-112, 53-6-111 and 53-6-131, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1986 MAR p. 1321, Eff. 8/1/86; AMD, 1987 MAR p. 2164, Eff. 11/28/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 479.)

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## GENERAL MEDICAID SERVICES

37.85.502

37.85.502 SANCTIONS (1) The following sanctions may be invoked against providers based on the grounds specified in ARM 37.85.501:

- (a) Termination from participation in the medical assistance program.
- (b) Suspension of participation in the medical assistance program.
- (c) Suspension or withholding of payments to a provider.
- (d) Shortening of an existing provider agreement as permitted by the terms of such agreement.

(e) Required attendance at provider education sessions, the cost of which shall not be reimbursed by the department or any of its programs.

(f) Required prior authorization for provision of services.

(g) 100% review of the provider's claims prior to payment.

(h) Referral to the department of revenue for any action deemed necessary.

(i) In addition to the sanctions listed above, long term care facilities shall be subject to termination of participation when the deficiencies resulting from failure to meet conditions or standards of participation pose immediate jeopardy or the denial of payments for new admissions if the facility's deficiencies resulting from failure to meet conditions or standards of participation do not pose immediate jeopardy. Federal laws regarding termination from participation and intermediate sanctions provided in 42 U.S.C. 1396a(i), 42 CFR 442.2, and 42 CFR 442.117 through 442.119 are hereby incorporated by reference. A copy of 42 U.S.C. 1396a(i), 42 CFR 442.2, and 42 CFR 442.117 through 442.119 may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951; or

(j) Notification to the public of sanctions taken against a provider. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-108, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112, 53-6-106, 53-6-107 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1987 MAR p. 2164, Eff. 11/28/87; TRANS, from SRS, 2000 MAR p. 479.)

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Sanction Rules

GENERAL MEDICAID SERVICES

37.85.505

37.85.505 FACTORS GOVERNING IMPOSITION OF SANCTION

(1) The decision to impose sanctions and which sanctions to impose shall be within the discretion of the department except as provided in (3).

(2) The following factors shall be considered in determining the sanction(s) to be imposed:

- (a) seriousness of the offense(s);
- (b) extent of violations;
- (c) history of prior violations;
- (d) prior imposition of sanctions;
- (e) prior provision of provider education;
- (f) provider willingness to comply with program rules;
- (g) whether a lesser sanction will be sufficient to remedy the problem;
- (h) actions taken or recommended by peer review groups or licensing boards.

(3) Where a provider has been found by a court of competent jurisdiction in either a civil or criminal proceeding to have defrauded the Montana medical assistance program, or has been previously suspended due to program abuse, or has been terminated from the medicare program for fraud or abuse, the department may terminate the provider from the medical assistance program. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-108, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112, 53-6-106, 53-6-107 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; TRANS, from SRS, 2000 MAR p. 479.)

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## SECTION:

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Sanction Rules

## GENERAL MEDICAID SERVICES

37.85.506

37.85.506 SCOPE OF SANCTION (1) A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due consideration to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to an affiliate where such conduct was accomplished within the course of the affiliate's official duty or was effectuated by the provider with the knowledge or approval of the affiliate.

(2) Suspension or termination from participation of any provider shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the department or its fiscal agents for any services or supplies provided to persons eligible for the Montana medical assistance program except for those services or supplies provided prior to the suspension or termination. Providers of long term care facility services may submit claims for supplies and services provided for up to 30 days after the date of termination to allow for the transfer of recipients.

(3) No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the department or its fiscal agents for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Montana medical assistance program except for those services or supplies provided prior to the suspension or termination. Providers of long term care facility services may submit claims for supplies and services provided for up to 30 days after the date of termination to allow for the transfer of recipients.

(4) When the provisions of (3) of this rule are violated by a provider of services which is a clinic, group, corporation, the department may suspend or terminate such organization and/or any individual person within said organization who is responsible for such violation. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1987 MAR p. 2164, Eff. 11/28/87; TRANS, from SRS, 2000 MAR p. 479.)

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## SECTION:

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GENERAL MEDICAID SERVICES

37.85.507

37.85.507 NOTICE OF SANCTION (1) When a provider has been suspended or terminated, the department shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed. (History: Sec. 53-6-111, MCA; IMP, Sec. 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; TRANS, from SRS, 2000 MAR p. 479.)

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## GENERAL MEDICAID SERVICES

37.85.511

37.85.511 PROVIDER EDUCATION (1) Except where termination has been imposed, the department may in its discretion direct each provider, who has been sanctioned, to participate in a provider education program as a condition of continued medicaid participation.

(2) Provider education programs may include any of the following at the discretion of the department:

- (a) instruction in claim form completion;
- (b) instruction on the use and format of provider manuals;
- (c) instruction on the use of procedure codes;
- (d) instruction on statutes and regulations governing the Montana medicaid program;
- (e) instruction on reimbursement rates;
- (f) instructions on how to inquire about coding or billing problems;
- (g) any other matter as determined by the department. (History: Sec. 53-6-111, MCA; IMP, Sec. 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; TRANS, from SRS, 2000 MAR p. 479.)

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Sanction Rules

37.85.512

DEPARTMENT OF PUBLIC HEALTH  
AND HUMAN SERVICES

37.85.512 NOTICE OF ADVERSE ACTION (1) As provided in this rule, the department must notify a provider of any adverse action it will take on a determination that the provider has engaged in fraud or abuse or has received payment to which the provider is not entitled. The notification must include:

- (a) a description of the fraud, abuse or overpayments;
- (b) the dollar value of any overpayment; and
- (c) the adverse action to be taken or sanction to be imposed by the department;

- (d) explanation of any actions required of the provider;
- (e) the provider's right to a fair hearing.

(2) The department is not required to notify a provider pursuant to (1) until after the department has determined that fraud, abuse or an overpayment has occurred, the dollar amount of any overpayment and that a particular adverse action will be taken by the department against the provider, such as recovery of an overpayment or imposition of a sanction. The department is not required to notify the provider when the department merely suspects or has information which suggests that fraud, abuse or an overpayment has occurred or when the department has not determined to take a particular adverse action in response to the fraud, abuse or overpayment.

(3) Subject to the provisions of (4), the department must notify the provider as required in this rule within 45 days after the department has determined that fraud, abuse or an overpayment has occurred, the dollar amount of any overpayment and the adverse action that will be taken against the provider. The department's failure to notify a provider as required by this rule is not a defense to recovery of the overpayment or imposition of the sanction, but the department may be required to provide a new notice in compliance with this rule.

(4) This rule shall not be construed to require that the department investigate, complete an investigation, make a determination or take any other action regarding a potential fraud, abuse or overpayment within any particular time.

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37.85.512

(5) While this rule does not require the department to act within any particular time, if any governmental agency or entity is conducting an investigation of a provider, the department shall not in any event be required to notify the provider of a violation or overpayment until the investigation is concluded and enforcement proceedings, if any, have been completed, if in the sole discretion of the department or the governmental agency or entity conducting the investigation, earlier notification would interfere with or jeopardize the investigation, recovery of an overpayment or imposition of a sanction. (History: Sec. 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

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SUBJECT:

Sanction Rules

37.85.513

DEPARTMENT OF PUBLIC HEALTH  
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37.85.513 SUSPENSION OR WITHHOLDING OF PAYMENTS PENDING FINAL DETERMINATION (1) Where the department has notified a provider of a violation or an overpayment pursuant to ARM 37.85.512 the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payments pending a final determination.

(2) Where the department intends to withhold or suspend payments it shall notify the provider in writing at least 10 days prior to commencement of withholding and shall include a statement of the provider's right to request an informal reconsideration of such decision as provided in ARM 37.5.305. This rule does not require that an informal reconsideration or any hearing be conducted prior to the withholding or suspension of payments.

(3) Where the department has terminated or suspended a provider, the provider shall be eligible to bill for covered services for the period covered by the suspension or termination if an appeal is decided in the provider's favor. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

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**DFS Policy Manual: Adult Protective Services  
Responding to the Referral**

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**Investigation of Referrals**

The DFS social worker must respond to a report of alleged abuse, neglect, sexual abuse or exploitation of an aged person, disabled adult or person with a developmental disability. If a DFS social worker is not allowed entry to investigate, obtaining a court order to investigate should be considered. (See Section 401-8 of this manual for this process.)

The local DFS office must record all protective service referrals in the Adult Protective Service Log.

**Abuse in Long-Term care Facility**

If an aged person is living in a long-term care facility, referral must be made to the long-term care ombudsman for investigation as soon as possible.

Long-term care facilities are facilities that provide skilled nursing care, intermediate nursing care, or personal care as defined in 50-5-101, MCA.

The referral to the Long Term Care Ombudsman (LTCO) can be made by phoning the toll free Senior Citizen's Hot Line, 1-800-332-2272, or in Helena, 444-4676 or write to the Long-Term Care Ombudsman, Office on Aging, P.O. Box 8005, Helena, Montana 59604, marked **confidential**.

**Response Time**

Any referral of an aged person, disabled adult or developmentally disabled person who is alleged to be suffering from physical and/or mental injury or sexual abuse must be investigated promptly.

Other protective service referrals may be considered non-emergency. Examples of a non-emergency referral may be the inappropriate use of funds or verbal abuse of an elderly person.

**Persons Contacted**

The client should be contacted regardless of his or her physical or mental capacity because the client is primary to any planned intervention. It may be necessary to contact guardians, relatives, or friends to enlist their aid or to obtain information for making an adequate investigation. The DFS social worker may need to contact other professionals or agencies for needed information.

**DFS Policy Manual: Adult Protective Services  
Responding to the Referral**

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**Release of  
Information**

In cases where a DFS social worker seeks information from another professional or agency and the professional or agency will not release the information because it is confidential, the DFS social worker should obtain written consent signed by the client that authorizes the release of information to the DFS social worker. A court order may be necessary if the client refuses to sign a release and the information is vital to the investigation.

**Home Visits**

The initial contact should be in the client's place of residence with prior notification to the client when possible.

After the initial contact, additional home visits and office visits may be required. Visits should be scheduled, as much as possible, at the client's convenience.

**Results of the  
Investigation**

The DFS social worker conducting the investigation must determine if the complaint is substantiated and if protective services are needed. An assessment of risk must be completed on each case using the DFS-501, APS Risk Assessment.

**Risk Assessment**

The decisions to assign a level of risk and to provide adult protective services are professional judgments by the DFS social worker and/or the DFS social worker supervisor. The risk assessment instrument is used to assist in making, not dictating, decisions.

The DFS social worker must make written documentation that the referral is substantiated, unsubstantiated, or unfounded.

- Investigation records will reflect the assessment of risk and indicate the reasons the case is substantiated, unsubstantiated, or unfounded. The DFS-502 APS Investigative Summary must be used for this purpose. The worksheets DFS-502(A) through DFS-502(E) can be used to support this assessment. This assessment must be completed as soon as possible but not later than 60 days from the date of the referral. Collateral information to support this assessment is recorded on the DFS-504 APS Contact and Narrative Summary.

## DFS Policy Manual: Adult Protective Services Responding to the Referral

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- The assessment must be completed within 10 working days if the alleged perpetrator has been suspended from employment due to the allegation (see Section 403-1 of this manual).
- DFS social workers can use photographs and physician's reports to support assessment decisions. The process for gathering this type of evidence is found in Section 401-9 of this manual.
- A substantiated case must have a case plan that is recorded on the DFS-503 APS Case Plan.
- In substantiated cases the narrative must include identification of resolved and unresolved problems.
- If the determination is made that an older person or a person with developmental disabilities is at substantial risk of death or serious physical injury, emergency protective services should be considered. Section 401-10 of this manual covers emergency protective service procedures.

### Social Worker Reports in Substantiated Cases

Since the Elderly and Developmentally Disabled Abuse Prevention Act now makes the first conviction of abuse, neglect, sexual abuse or exploitation of an elderly person or person with developmental disabilities a misdemeanor, information on substantiated cases must be provided to the county attorney so that he/she may consider prosecution of the perpetrator. Procedures and information to be used to notify the county attorney shall be developed jointly by the DFS social worker and/or supervisor and the county attorney. The county attorney can review the APS log periodically if he/she wishes to see the type of referrals DFS is responding to.

If the referral appears to be a criminal act, the DFS worker should call the appropriate county attorney and law enforcement agency to conduct the investigation. The call must be followed by sending a copy of the Intake Report, DFS-500.

## DFS Policy Manual: Adult Protective Services Responding to the Referral

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Information must be shared with County Attorney

The county attorney will use reports from the department to determine if prosecution is indicated, therefore, the following information should be shared:

- Adult Protective Services Log (periodically) DFS-110B or the DFS-500 Adult Intake Report
- DFS-502 APS Investigative Summary
- DFS-501 APS Risk Assessment Form
- DFS-503 APS Case Plan
- DFS -504 APS Contact and Narrative Summary (if collateral information pertinent to the case is recorded)

**Notice to Named Perpetrator**

Notice of substantiation of abuse, neglect, sexual abuse or exploitation must be sent by the investigating social worker (or hand delivered, if necessary) to the person or persons named as the perpetrator(s). A copy of the notice must be in the file. The notice must state the following:

- the allegation, but not the name or identity of the person who made the referral;
- that the investigation substantiated abuse, neglect, sexual abuse or exploitation:
- the possible impact of substantiation on the person's ability to be licensed or work in certain fields; and
- the person's right to have the substantiated report reviewed if such a review is requested in writing within 30 days of the date of the notice letter.

Please see the **SAMPLE LETTER** at the end of this section. It is preferable that the letter be sent by **Certified Mail**.

**DFS Policy Manual: Adult Protective Services  
Responding to the Referral**

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**Exceptions**

If the notice will place the client in danger, an exception may be approved by the CSWS following review by the supervisor and regional administrator in consultation with legal staff. Such exception will be noted in the case file.

Notification will not be sent in substantiated self neglect cases where the perpetrator is also the victim.

Notification will not be sent to perpetrators in those cases where a DFS social worker has been asked by the long term care ombudsman or the Department of Health and Environmental Sciences to investigate abuse, neglect, or exploitation in a long-term care facility. In such cases the report should be sent to the agency requesting the investigation.

Notification must be sent to the guardian of a disabled person, when DFS has named the disabled person as a perpetrator in a case of substantiated abuse, neglect, sexual abuse or exploitation.

**DFS Investigation  
Not a Criminal  
Investigation**

DFS social worker's investigation and assessment of risk are done to determine the client's need for adult protective services and are not designed as a criminal investigation. DFS social worker's must exercise caution when conducting their investigation in regard to information gathered that could be used as evidence in a criminal case. The DFS social worker must carefully document the information outlined in the paragraph above and safeguard any supporting documentation so it can be turned over to the county attorney. Criminal investigation is done by police, sheriff's office or other appropriate law enforcement professionals.

**Special  
Requirements  
Involving Persons  
with  
Developmental  
Disabilities**

When a DFS social worker has substantiated that a staff person or a person in the care of a provider of developmental disabilities services has abused, neglected, sexually abused or exploited an adult with developmental disabilities and makes a recommendation to the county attorney to consider prosecution of the perpetrator, an APS team must be convened to make a recommendation for or against the prosecution. See Section 402-1.

**DFS Policy Manual: Adult Protective Services  
Responding to the Referral**

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**APS Team**

The APS team should be convened for this purpose within 15 working days from the day DFS recommended that prosecution be considered by the county attorney.

When an APS team meets to make a recommendation in a case involving an adult in the care of a provider of developmental disabilities services the team must include a representative from the Developmental Disabilities Division of the Department of Social and Rehabilitation Services and a provider not involved in the matter.

**Convening the Team**

The department or county attorney determines which cases involving an adult with developmental disabilities the team may need to consider, except in those cases where the DFS social worker is recommending that the county attorney consider prosecution of the perpetrator under Section 52-3-825 MCA of the Montana Elder and Developmentally Disabled Abuse Prevention Act. Others involved with the alleged victim may request the team to meet, but the final determination of convening the team is the responsibility of the department and/or county attorney based on the facts of the case and the needs of the individual.

The requirement to convene an APS team to make a recommendation regarding prosecution does not apply if the DFS social worker has referred the case to the county attorney and law enforcement for criminal investigation and the county attorney and/or law enforcement have accepted responsibility for the case.

**Appeal Process**  
Written Appeal

In cases where the department substantiates a report of abuse, neglect, sexual abuse or exploitation, the alleged perpetrator named in the record has a right to request that the department amend or make additions to the case record on the grounds that the information is incomplete or incorrect.

The alleged perpetrator making the request must:

1. Make a written request for departmental review of the record within 30 days of the date of the notice of substantiated abuse, neglect, or exploitation;

**DFS Policy Manual: Adult Protective Services  
Responding to the Referral**

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2. State the reasons in writing why he/she believes the determination to be in error; and
3. Send or have the local DFS office forward the request for review to the DFS regional administrator of the DFS region where the records originated.

The regional administrator or his/her designee(s) will evaluate the information and determine whether to amend the record. The regional administrator will send the response to the person requesting the review and to the DFS social worker whose case record is being reviewed. The DFS social worker will file in the case record the person's request for review and the regional administrator's response.

If the person requesting the review is not satisfied with the regional administrator's response they may request a review by the director within 15 days of receiving the regional administrator's response. All correspondence regarding this request will also be filed in the case record.

- In cases where a perpetrator has been suspended from employment due to the DFS substantiation of abuse, neglect, sexual abuse or exploitation and has requested review by the regional administrator, the review and response should be completed within 10 working days whenever possible.
- Regional administrators may base their determinations on findings of the district court or upon previous determinations made regarding a request for amendments or additions to the record at issue.
- In those cases where the director is reviewing the case the director will not conduct an independent investigation. The director can review the relevant records and documentation and consult with individuals who may have relevant information.
- DFS must give the county attorney all information regarding changes made as a result of a review.

**DFS Policy Manual: Adult Protective Services  
Responding to the Referral**

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<b>Informal Complaint Process</b>	Whenever there are public complaints about Department of Family Services staff the requirements of Section 103-2 of the DFS Administrative Manual must be followed.
<b>Failure to Report</b>	If the DFS social worker has reasonable evidence that a person who is required to report elder abuse or abuse of a developmentally disabled person, as listed in Section 401-6 of this manual, has willfully failed to report the incident, the name of that person plus the evidence must be provided to the county attorney who will determine if prosecution for failure to report is indicated.
<b>NOTE</b>	If prosecution is recommended, the APS team must be convened in accordance with 402-1.
<b>References</b>	Section 52-3-204, MCA Section 52-3-804, MCA Section 52-3-811, MCA Section 52-3-602 through 604, MCA Section 52-3-825, MCA Section 52-4-104, MCA Section 11.9.109, ARM Section 11.5.203, ARM Section 11.9.602, ARM Section 11.5.609, ARM

**DFS DFS Policy Manual: Adult Protective Services  
Releasing Case Record Information**

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**Releasing Case  
Record  
Information**

All APS records concerning aged persons or adults with developmental disabilities must be kept confidential, but may be released, when requested, to the following:

- A physician who is caring for the elderly or developmentally disabled person;
- legal guardian or conservator of an alleged victim, if that person is not the alleged perpetrator and the identity of the reporter is protected;
- the person named in the report, if not legally incompetent;
- person engaged in research if the perpetrator was convicted and victims names are not released;
- APS team
- DFS or SRS employees when the information is necessary to provide services to the client;
- guardianship programs recognized by DFS;
- providers involved in a licensing dispute with DFS;
- providers of services to aged persons or persons with developmental disabilities, if deemed by DFS to be in the client's best interest; and
- a state agency that issues a license held by the alleged perpetrator.

Records must be released, upon request, to the following:

- county attorney or law enforcement in connection with an investigation;

**DFS DFS Policy Manual: Adult Protective Services  
Releasing Case Record Information**

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- court; or
- grand jury.

The DFS social worker and supervisor must determine what case record information may be shared. This determination will be based on the needs of the authorized requestor, listed above, to have information to serve the interests of the alleged victim and any potential harm that may occur if the records are released.

Disclosure of case record information may be prohibited or challenged by the county attorney if a criminal investigation or proceeding involving the alleged victim is in process.

**NOTE**

The above requirements for releasing case record information also apply to those disabled adults not covered under the Montana Elder and DD Abuse Act. (For definition of disabled see Section 401-5).

**Reference**

Section 52-3-813 MCA

Department of Public Health  
and Human Services

SECTION:

APPENDIX

HOME HEALTH SERVICES

SUBJECT:

Example of Medicaid  
Identification Card

99/99/99 99999\*\*\*\*9.99 99999 99999999999999

\*\*\*\*\*9.99

Last Name, First Name MI  
Street Address  
Street Address  
City, State Zip Code

# MEDICAID IDENTIFICATION CARD - PUBLIC HEALTH AND HUMAN SERVICES

PERIOD VALID: DECEMBER 1 TO DECEMBER 31, 1997 -XXX COUNTY NAME XXX

NAME	MEDICAID #	BIRTHDATE	SX	QMB	INS	MEDICARE	COPAY
DOE, JANE	555112222	01/01/93	F	NO			
FULL	PASSPORT: DR. JOHN JONES					(406)555-9999	
DOE, JOHN	111225555	01/02/92	M	NO			
FULL	HMO: YELLOWSTONE COMMUNITY HEALTH					(406)222-9999	
DOE, JEFF	555121212	01/04/55	M	NO			
BASIC	MANAGED CARE: PENDING						*
DOE, JENNIFER	444556666	01/01/80	F	NO			
FULL	MANAGED CARE: EXEMPT						

ASTERISK UNDER COPAY DENOTES PERSON HAS MET COPAY OBLIGATION

&gt;&gt;&gt;&gt;&gt;&gt;&gt;&gt;&gt;PLEASE SEE ADDITIONAL INFORMATION ON BACK OF CARD&lt;&lt;&lt;&lt;&lt;&lt;&lt;&lt;&lt;&lt;

## TPL INFORMATION

1.	XXXXXXXXXX	XXXXXXXXXX	XXXXXX	XXXXXX,	X
	999-99-9999				
2.	XXXXXXXXXX	XXXXXXXXXX	XXXXXX	XXXXXX,	X
	999-99-9999				
3.	XXXXXXXXXX	XXXXXXXXXX	XXXXXX	XXXXXX,	X
	999-99-9999				

## RESTRICTED INFORMATION

XX  
 XX  
 XX  
 XX  
 XX

SECTION:

APPENDIX

SUBJECT:

Example of Medicaid  
Identification CardW A R R A N T                      A R E AGENERAL MEDICAID INFORMATION:1-800-362-8312**INFORMATION FOR CLIENTS****REFER TO YOUR HANDBOOK OR MEDICAID BROCHURE FOR ADDITIONAL  
INFORMATION OR EXCEPTIONS**

Please remember that Medicaid will pay for ONLY medically necessary and appropriate services. Most Medicaid services have limitations. Check with the General Medicaid Information line to see if a service is covered under Medicaid. If you have further questions, ask the County Welfare Office or Office of Human Services for a Medicaid brochure. If you have "Restricted To" under your name, you are required to get all services from that provider, unless there is a referral to another provider. If you have "Prior Authorization" under your name, you are required to get prior authorization from Medicaid for all services. If you have the word "BASIC" under your name, some Medicaid services are not available to you. See the chart below to find out if a particular Medicaid service is available to you. NOTE: Medicaid may require that you pay a copayment, ranging from \$.50 to \$100.00.

**RIGHT TO APPEAL**

You have the right to a fair hearing when a medical service you receive is denied payment. Please call 1-800-362-8312, or write to P O Box 202951 Helena MT 59604 if you want to appeal a denial.

**HEALTH INSURANCE**

Notify your Eligibility Specialist of any changes in your private health insurance coverage.

SERVICE	SERVICE INCLUDED IN BASIC PLAN:	NEED HMO PROVIDER APPROVAL:	NEED PASSPORT PROVIDER APPROVAL:
Ambulance (Emergency)	Yes	No	No
Birth Control	Yes	No	No
Dentist/Dentist	**Limited**	No	No
Doctor/Clinic	Yes	Yes	Yes, except for birth control, pregnancy related services and immunizations
Drugs	Yes	No	No
Emergency Room	Yes	Yes, unless life threatening	Yes, unless life threatening
Eye Exam	**Limited**	No	No
Eyeglasses	NO	No	No
Hearing Aids and Audiology	NO	No	No
Home Health	Yes	Yes	Yes
Hospital-Inpatient	Yes	Yes	Yes, except for having baby delivered
Hospital-Outpatient	Yes	Yes	Yes
Mental Health	Yes, call for prior authorization 1-888-599-2233	No, call for prior authorization 1-888-599-2233	No, call for prior authorization 1-888-599-2233
Personal Care Attendant	NO	No	No
Podiatry	Yes	Yes	No
Physical, Occupational, Speech Therapy	Yes	Yes	Yes
Supplies and Equipment	**Limited**	No	No

For \*\*Limited\*\* services under the BASIC plan, please call 1-800-362-8312 (Medicaid Hotline).  
For Mental Health services call 1-888-599-2233, prior to appointment

**SHOW YOUR CARD****SHOW YOUR CARD****SHOW YOUR CARD**

May 1, 1999

SENIOR &amp; LONG TERM CARE

Page 2 of 2

Department of Public Health  
and Human Services

HOME HEALTH SERVICES

SECTION:

APPENDIX

SUBJECT:

Medicaid Restricted Card

**When a recipient's utilization of Medicaid services is excessive, inappropriate, or fraudulent, a recipient is restricted (LOCKED-IN) to designated, primary providers. The most common restriction is to a single physician and pharmacy.**

When a recipient is on prior authorization restriction, a provider must call the Department's Surveillance/Utilization Review (SUR) Unit to assure Medicaid payment for non-emergency medical or pharmacy services, Monday through Friday, 8:00 to 5:00 at 444-4168. Only true emergency services will be assured payment after hours and on weekends.

Non-emergency services are those which do not meet the following definition of emergency. "Emergency services are necessary treatment of accidental injury which require immediate attention or treatment of a life threatening medical condition."

Please see the following examples of the Medicaid ID card messages indicating Restricted Recipients and Prior Authorization Recipients.

**EXAMPLE ID CARD: RESTRICTED MESSAGE**

"JANE DOE IS RESTRICTED TO: J.F.SMITH, M.D.; Rx PHARMACY; AND L.S. TOOTH, DDS. MEDICAID PAYMENT WILL NOT BE MADE TO OTHER PHYSICIANS, PHARMACIES, DENTISTS, OR HOSPITAL EMERGENCY ROOMS EXCEPT FOR ACCIDENTS REQUIRING IMMEDIATE ATTENTION, LIFE THREATENING PROBLEMS OR REFERRAL BY THE ABOVE NAMED PHYSICIAN."

**EXAMPLE ID CARD: PRIOR AUTHORIZATION MESSAGE**

"JOHN DOE IS RESTRICTED. PRIOR AUTHORIZATION IS REQUIRED FOR ALL NON-EMERGENCY MEDICAL AND PHARMACY SERVICES. FOR PRIOR AUTHORIZATION CALL SUR UNIT AT 444-4168. SERVICES FOR EMERGENCY ROOM VISITS WILL BE PAID ONLY IF THEY ARE FOR ACCIDENTS REQUIRING IMMEDIATE ATTENTION OR LIFE THREATENING PROBLEMS."

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APPENDIX

SUBJECT:

Medicaid Restricted Card

The restricted recipient's Medicaid ID Card alerts all providers to the restriction. RECIPIENTS AND PROVIDERS HAVE JOINT RESPONSIBILITY FOR EXCHANGE OF INFORMATION CONTAINED ON THE MEDICAID IDENTIFICATION CARD. However, assistance on lock-in requirements specific to a recipient may be obtained by calling the SUR Unit at 444-4168.

## **"PRIMARY" PROVIDER**

When a restricted recipient is locked-in to designated primary providers, the names of the primary providers are listed on the Restricted Card. All services are restricted unless referred by the primary care provider.

All other providers, including hospitals, are at risk of being denied Medicaid payment unless a referral was made by the primary physician, or services were for a bona fide emergency situation. A restricted recipient is responsible for payment of unauthorized services.

A primary provider is responsible to oversee a recipient's health care needs and monitor their use of services. The primary providers should work together to ensure the best possible medical care for a recipient. This includes providing services that are necessary and appropriate, either directly or through referral to a specialist. SUR will confer with the primary providers for medical opinions. The Department appreciates the help and cooperation of primary providers in the medical management of restricted recipients.

For billing information about Medicaid's Managed Care Program "Passport to Health", see Section XI. For information about Medicaid's HMO Program, see Section XII.

**ALL MEDICAL PROVIDERS SHOULD INSIST UPON SEEING  
EVERY MEDICAID RECIPIENT'S IDENTIFICATION CARD!!**

o o o

**MONTANA MEDICAID PROGRAM**

**Department of Public Health and Human Services  
Laurie Ekanger, Director**

**Health Policy and Services Division  
Nancy Ellery, Administrator**

**PO Box 202951, 1400 Broadway  
Cogswell Building, Room A206  
Helena, MT 59620-2951  
(406) 444- 4540**

**May 1999**

## **MISSION STATEMENT**

**To assure that necessary medical care is available to all eligible low income Montanans.**

**In order to fulfill its mission, the Medicaid program must:**

- promote the maintenance of good health by program recipients;**
- assure recipients have access to necessary medical care;**
- assure that quality of care meets acceptable standards;**
- promote the appropriate use of services by recipients;**
- promote the delivery of appropriate care by service providers;**
- assure that service providers are paid quickly and accurately; and**
- assure that services are purchased in a cost-effective manner.**

## SERVICE DELIVERY COORDINATION

The delivery of services and administrative activities of the Medicaid Program are located primarily within the Health Services and Policy Division. These services are coordinated with many other divisions in the Department of Public Health and Human Services (DPHHS) as well as other state and federal agencies and private providers. Determination of Medicaid eligibility is administered by the DPHHS Division of Child and Family Services through the local County Welfare/Human Services. Eligibility questions should be directed to these offices. Mental health services are administered by the DPHHS Addictive & Mental Disorders Division. Long-term care services are administered by the DPHHS Senior and Long Term Care Division. Utilization review is administered by the DPHHS Quality Assurance Division.

The Division contracts with Consultec, Inc. to enroll Medicaid providers and process Medicaid claims. Consultec's toll free phone number is 1-800-624-3958.

The Division contracts with Unisys to perform much of the administrative oversight for Passport and the HMO Program. Part of their duties include operating a toll free recipient hotline 1-800-362-8312 and a toll free provider hotline 1-800-480-6823.

## GENERAL STATEMENT/CO-PAYMENT

Recipients are responsible for paying the co-payment amounts designated by Medicaid. CHILDREN (under age 21), PREGNANT WOMEN, and NURSING HOME RESIDENTS ARE EXEMPT from co-payments. Co-payments MAY NOT be charged for services provided in an emergency or for family planning.

# SERVICE

# SCOPE

# LIMITATIONS

# REIMBURSEMENT

# COPAY

1. Ambulatory Surgical Centers Bob Wallace 444-7018)	Selected procedures provided on an out-patient basis.	ASC must be licensed and meet Medicare participation standards.	Department fee schedule does not include physician services, ambulance, or major prosthetic appliances.	\$1.00 per visit..
2. Audiology Services (ARM 46.12.533) Vacant 444-4066	Hearing aid evaluation only.	Ordered by physician or mid-level practitioner.	Department fee schedule.	\$1.00 per service.
3. Chemical Dependency Treatment Services (Outpatient) Michelle Gillespie 444-3182	Intensive outpatient, basic outpatient and aftercare services.	-Must be determined appropriate by a Certified Chemical Dependency Counselor. -Limited to individuals under 21 years of age. -Providers must be approved by Dept. Of Corrections and Human Services.	Department fee schedule.	Exempt
4. Chiropractic Services (ARM 46.12.515) Michelle Gillespie 444-3182	Manual manipulation of the spine and limited x-rays.	Limited to individuals under age 21.	Department fee schedule.	Exempt.
5. CLINICS Diagnostic Clinic (ARM 46.12.570, 571, 573) Randy Bowsher 444-3995	Evaluation services in diagnosis and evaluation centers.	Services cannot exceed amount, duration, and scope of services outside clinic setting.	Department fee schedule.	\$1.00 per visit.
Federally Qualified Health Centers (FQHC) (ARM 46.12.1701, 1703, 1705 and 1707) Debra Stipcich 444-4834	Medicaid covered ambulatory services.	Federally deemed clinic receiving or qualified to receive funds under Section 329, 330 or 340 of the Public Health Service Act.	100% of reasonable cost through an all inclusive interim rate and end of period cost settlement.	\$2.00 per visit.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

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<b>Freestanding Dialysis Clinics</b> (ARM 46.12.1501 and 1505)  Debra Stipcich 444-4834	Outpatient maintenance dialysis; training for self dialysis and home dialysis.	Coordinated with Medicare renal disease program; patients must be diagnosed as suffering from chronic ESRD.	All inclusive composite rate for services with a separate fee for drugs.	\$2.00 per visit.
<b>Public Health Clinics</b> (ARM 46.12.570, 570 & 573)  Vacant 444-4066	Outpatient physician, nurse specialist, physician assistant, nursing services.		Department fee schedule	\$1.00 per visit.
<b>Rural Health Clinics (RHC)</b> (ARM 46.12.1601, 1603, 1605 & 1607)  Debra Stipcich 444-4834	Outpatient services not including dental provided by hospital affiliated-Provider Clinic-or free standing-Independent-clinic.	Medicare certified Clinic located in rural area designated a shortage area by HHS; not a rehab or primarily a facility to treat mental diseases.	Provider Clinics-100% of reasonable cost; Independent Clinics-100% of reasonable cost through an all inclusive interim rate not to exceed an annual cap set by HHS	\$2.00 per visit.
<b>Mental Health Services</b> <i>Addictive &amp; Mental Disorders</i> Randy Poulsen 444-2706  <i>Montana Community Partners.</i> Contractor 1-888-599-2233 (recipients) 1-800-926-6636 (providers)	All services medically necessary in the treatment of a specific range of mental illness diagnoses are provided through the Mental Health Access Plan, the state's managed care program, which is operated by Montana Community Partners.	Most services must be pre-authorized. A recipient's first 15 outpatient therapy or medication management sessions do not require authorization..	According to provider's contract with Montana Community Partners.	Exempt.
<b>6. Dental services, including denture services provided by denturists</b> (ARM 46.12.601)  Michelle Gillespie 444-3182	Services listed in Department rules.	-Extensive dental services, including dentures, must be prior authorized by the Department. -Services provided by a denturist must be prescribed by a dentist	Department fee schedule.	\$1.00 per service.
<b>7. Dietitian Services</b>  Michelle Gillespie 444-3182	Evaluation and treatment by a licensed nutritionist or dietician	Limited to individuals under 21 years of age.	Department fee schedule	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

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8. <b>Optometric services</b> (ARM 46.12.901, 902, 905, 911 and 912)  Vacant 444-4066	Services listed in Department rules.	-Eye examination limited to one annually.	Department fee schedule	\$1.00 per service
9. <b>Eyeglasses</b> (ARM 46.12.901, 902, 905, 911 & 912).  Vacant 444-4066	Services and items listed in Department Rules.	-One pair of eyeglasses every two years for individuals 21 and over, unless there's a significant change in prescription or the individual has had cataract surgery.  -Eyeglasses are through Volume Purchasing Contract.	Department fee schedule	\$0 for Eyeglasses. \$1.00 per dispensing fee.
10. <b>Family Planning Services</b> (ARM 46.12.575)  Randy Bowsher 444-3995	Family planning services and supplies for individuals of child-bearing age provided by Title X Family Planning Clinics.	-Sterilizations/abortions limited by federal requirements.	Department fee schedule.	Exempt.
11. <b>Health Maintenance Organizations (HMOs)</b>  Maureen O'Reilly 444-4148	Services and items listed in Department Rules.	Only certain services are managed by the HMO. Limited to certain geographic areas.	Per contract.	Exempt for HMO covered service.
12. <b>Hearing Aids</b> (ARM 46.12.540)  Vacant 444-4066	Hearing Aids, repairs, and accessories.	-Ordered by physician or mid-level practitioner. -Prior authorized by the Department. -Hearing evaluation required by audiologist.	Department fee schedule.	\$1.00 per service.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

**SERVICE**

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<p>13. <b>Home and Community Based Services (HCBS Medicaid Waiver)</b> (ARM 46.12.1401)</p> <p><i>Senior &amp; Long Term Care</i></p> <p>Cecilia Cowie 444-4150</p> <p>Annette Marron 444-4142 Claims Resolution</p>	<p>In-home services designed to serve individuals in the community who would otherwise require nursing home or hospital care. Services include case management, homemaker, personal care, respite, adult day care, medical alert, environmental modifications/ adaptive equipment, meals, dietitian, social transportation, habilitation, respiratory therapy, nursing &amp; psychological consultation, adult residential, child care for children with AIDS &amp; special services for individuals with a traumatic brain injury.</p>	<p>-Recipient must meet nursing home or hospital level of care and services must be ordered by a physician. -Medicaid cost of care in community cannot exceed cost of institutional care.</p>	<p>Reimbursement varies by service</p>	<p>Exempt.</p>
<p>14. <b>Home Health Services</b> (ARM 46.12.550)</p> <p><i>Senior &amp; Long Term Care</i></p> <p>Barbara Smith 444-4064</p>	<p>Intermittent skilled nursing services, home health aide services, physical, occupational &amp; speech therapy services and supplies related to services delivered.</p>	<p>-Ordered by a physician. -Limited to a combined maximum 100 visits per state fiscal year except nursing services which have a limit of 75 visits per recipient per state fiscal year. More nursing visits may be available with prior authorization. -All Home Health Aid services must be prior authorized. -Recipient must be homebound OR cannot readily obtain needed medical services other than through a Home Health Agency. -Recipient receiving PCA services may not receive home health aid services.</p>	<p>Department Fee Schedule</p>	<p>\$2.00 per service. \$.50 per item for equipment and supplies.</p>

**EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID**

**SERVICE**                      **SCOPE**                      **LIMITATIONS**                      **REIMBURSEMENT**                      **COPAY**

<p><b>15. Home Dialysis Attendant Services</b> (ARM 46.12.560)</p> <p><i>Senior &amp; Long Term Care</i></p> <p>Barbara Smith 444-4064</p>	<p>Payment for trained dialysis attendants to assist dialyzing recipients at home.</p>	<ul style="list-style-type: none"> <li>-Provided only to recipients diagnosed by a physician as suffering from chronic end stage renal disease.</li> <li>-Provided only when there is no family member who can be trained to perform the dialysis.</li> <li>-Attendants must be licensed RN or LPN trained by home dialysis training center.</li> </ul>	<p>Department fee schedule</p>	<p>Exempt.</p>
<p><b>16. Hospice</b> (ARM 46.12.1819)</p> <p><i>Senior &amp; Long Term Care Div</i></p> <p>Barbara Smith 444-4064</p>	<p>Services and terms listed in Department rules.</p>	<ul style="list-style-type: none"> <li>-All services related to terminal condition to be provided by Hospice except for attending physician, personal care and HCBS waiver.</li> </ul>	<p>Federally set rates</p>	<p>Exempt.</p>
<p><b>17. Hospital</b></p> <p><b>In-Patient Hospital Services</b> (ARM 46.12.503)</p> <p>Jane Bernard 444-2528 Reimbursement and coverage</p> <p><i>Quality Assurance Div.</i></p> <p>Carol Jorgensen 444-0190 Utilization review</p>	<p>Medically necessary services ordinarily furnished in a hospital, including:</p> <ul style="list-style-type: none"> <li>-bed and board</li> <li>-nursing and other related services</li> <li>-use of hospital facilities</li> <li>-medical social services</li> <li>-drugs, biologicals, supplies, appliances and equipment</li> <li>-other diagnostic or therapeutic items or services</li> <li>-medical or surgical services provided by interns and residents-in-training</li> </ul>	<ul style="list-style-type: none"> <li>-Limited to medically necessary days, except drug/alcohol detox limited to four days unless condition requiring hospital care</li> <li>-Sterilization/abortions limited by federal requirements.</li> <li>-Acute Care Rehabilitation Units and Psychiatric Units.</li> <li>-Admissions subject to preadmission review by the department's designee or peer review organization.</li> <li>-Transplant services limited to Medicare approved facilities.</li> </ul>	<p>Prospective system based on diagnostic related groups (DRGs) for in-state and border hospitals. Cost based for free-standing psychiatric hospitals, distinct part rehabilitation units and out-of-state hospitals</p>	<p>\$100.00 per discharge from the hospital.</p>

**EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID**

# SERVICE

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<b>Out-Patient Hospital Services</b> (ARM 46.12.506)  Jane Bernard 444-2528	Medically necessary preventive, diagnostic, therapeutic, rehabilitative and palliative services.	-Limited to emergency room services and services covered by Medicaid in non-hospital setting and ordered by or under the direction of a physician.	Prospective payment for ER, ambulatory surgery, dialysis, laboratory, imaging and other diagnostic services. Retrospective reimbursement for all other outpatient services. (Rural hospitals & MAFs are not subject to prospective payment.	\$1.00 per line item.
<b>19. In-Patient Rehabilitation (Physical) Services</b>  Jane Bernard 444-2528 Reimbursement & Coverage  <i>Quality Assurance Division</i> Carol Jorgensen 444-0190 Joan Ashley 444-4121  <i>Senior &amp; Long Term Care</i> Kelly Williams 444-4147 Skilled Nursing Facilities Utilization Review  <i>Prior Authorization</i> Mountain Pacific Quality Health Foundation 443-4020 1-800-262-1545	Medically necessary services provided in the following settings: 1. Medicare certified hospitals; or 2. Medicare certified skilled nursing facility.	-Limited to acute care rehabilitation. -Limited to medically necessary days. -Rehabilitation centers which do not meet Medicare certification specified in "scope" are not covered. -Hospital admissions must be prior authorized by the Department's peer review organization. -Nursing home admissions must be prior authorized by the Department.	Cost-based.	Dependent of type of facility. See hospitals or nursing homes.
<b>20. Early, Periodic Screening Diagnosis &amp; Treatment (EPSDT)</b> (ARM 46.12.514, 515, 516)  Michelle Gillespie 444-3182	Screening and diagnostic services to determine and treat physical and mental illness or handicap.	Limited to individuals under 21 years of age.	Department fee schedule.	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

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21. Medical supplies, prosthetic devices, and durable medical equipment (ARM 46.12.801)  Frank Malek 444-4068 Coverage & Reimbursement <i>Quality Assurance Division</i>  Carol Jorgensen 444-0190  PA for Air Fluidized Beds, Augmentative Communication Devices, Hospital Beds Purchase), Wheelchairs & Items costing \$1,000 or more.)	Items listed in Department rules.	-Prior authorization as indicated in ARM. -Ordered by a physician.	Department fee schedule	\$.50 per item.
22. Mid-Level Practitioner Services (ARM 46.12.2010)  Randy Bowsher 444-3995	Limited to services provided within the scope of practice allowed by state law.	Services must be provided: 1. Within the level of physician supervision required by law; 2. Delivery of babies by nurse midwives must be in a licensed facility.	Department fee schedule.	\$2.00 per service. (Pregnant women are Exempt.)
23. Other laboratory and X-ray Services  Randy Bowsher 444-3995	Laboratory and x-ray services performed in a physician's office or in a free-standing facility, including a hospital acting as an independent laboratory. Services may not be provided in a hospital outpatient department or clinic.	Laboratory and radiology services as ordered by a physician, dentist or optometrist.	Department fee schedule, or for laboratory services, 60 percent of the Medicare prevailing whichever is lower.	\$2.00 per service in a physician's office.

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<p>24. <b>Out-of-State Services</b> (ARM 46.12.502)</p> <p><i>Quality Assurance Division</i> Joan Ashley 444-4121</p> <p><i>Prior Authorization</i> Mountain Pacific Quality Health Foundation</p> <p>443-4020 1-800-262-1545</p>	<p>All Medicaid Services which are not available in-state or within 100 miles of MT border subject to limitations specified in the next column.</p>	<p>-Out-of-state services are subject to the same limitations of the Montana Medicaid Program as in-state services. -May not go beyond 100 miles of the MT border for services, if the same services are available within that boundary. -Out-of-state services are allowed only when: .there is a medical emergency and the recipient's health would be endangered if he were required to travel to Montana to obtain the medical services; .the recipient travels to another state because the Department finds the required medical services are not available in Montana; or it is determined by the Department that it is general practice of recipients in a particular locality to use medical resources in another state; .the recipient or his representative can demonstrate to the satisfaction of the Department that out-of-state medical services and all related expenses will be less costly than in-state services; or .the recipient is a child residing in another state for whom Montana makes adoption assistance or foster care maintenance payments. .Inpatient services subject to preadmission review by the Department's peer review organization or designee.</p>	<p>Determined by type of service.</p>	<p>Amount is dependent on type of service provided. Refer to specific service for co-pay amount.</p>
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25. <b>Outpatient Drugs</b> (ARM 46.12.701)  Dorothy Poulsen 444-2738 Betty DeVancy 444-3457 Manufacturers Rebate	Drugs approved by FDA and requiring a prescription and over-the-counter drugs which are insulin, aspirin, laxatives and antacids.	-Prescribed by licensed practitioner. -Less-than -effective and experimental drugs are not covered. -Specific classes of drugs are limited to formulary products unless PA is obtained.	Maximum allowable cost (MAC) or estimated acquisition cost (EAC) plus dispensing fee.	\$1.00 per prescription Generic. \$2.00 per prescription brand name.
26. <b>Home Infusion Therapy</b> Rule # not yet assigned.  Dorothy Poulsen 444-2738	Services listed in Dept. Rules, provided by licensed home infusion therapy providers.	Prescribed by licensed practitioner. Specific therapies as limited by Dept. Rule. May not be provided in a hospital.	Pharmacy - see outpatient drugs. Nursing - Home Health or PDN per Diem - Department fee schedule.	Pharmacy - Exempt Nursing - See Home Health or PDN Per diem \$.50 per unit.
27. <b>Outpatient physical therapy, speech therapy and occupational therapy</b> (ARM 46.12.525A-46.12.527A)  Vacant 444-4066	Services listed in Department rules.	-Ordered by physician or mid-level practitioner -PT, ST & OT services limited to 70 hours per year without prior authorization by the Department. An additional 30 hours if determined medically necessary by the Department.	Department fee schedule.	\$1.00 per hour.
28. <b>PASSPORT TO HEALTH</b>  Maureen O'Reilly 444-4148	Recipients choose primary care provider who manages their care.	Limited to specific geographic areas of coverage, only certain services will be managed by primary care provider, refer to Department rules.	Department fee schedule.	Same as without PASSPORT.
29. <b>Personal Assistant Services</b> (ARM 46.12.555)  <i>Senior &amp; Long Term Care</i> Barbara Smith 444-4064	In-home services, including assistance with basic personal care functions such as bathing, grooming, dressing, toileting, transferring, walking, meal preparation, feeding, help with self-administered medications, escort to obtain medical care. Some assistance with home management.	-Ordered by physician. -Supervised by licensed nurse at least 180 days. -May not be provided in a long-term care facility, including a licensed personal care facility. -Limited to 40 hours per week.	Department fee schedule.	Exempt.

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Self-Directed Personal Assistance Services. (ARM 46.12.555)  <i>Senior &amp; Long Term Care Div.</i>  Barbara Smith 444-4064	Client-directed personal assistance services.	-Ordered by a physician or health care professional.	Department fee schedule.	Exempt.
30. Physician's Services (ARM 46.12.1201)  Randy Bowshe 444-3995  Fran O'Hara 444-3337 Claims Resolution	Services within the scope of the practice of medicine or osteopathy.	-Sterilizations/abortions limited by federal requirements. -Cosmetic services are not covered unless severe impairment to patient's physical and psycho-social well-being is demonstrated and treatment is prior authorized by the Department. -Treatment of infertility is not covered.	Department fee schedule.	\$2.00 per service.
31. Podiatry Services (ARM 46.12.521)  Randy Bowshe 444-3995	Services listed in Department rules.		Department fee schedule.	\$2.00 per service.
32. Presumptive Eligibility (ARM 46.12.3401)  Wendy Olson 444-4189	Ambulatory prenatal care for a time period of less than two months while formal application for public assistance is being made.	Ambulatory prenatal care (Approved Medicaid Services).	Department fee schedule	Exempt.

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

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33. Private Duty Nursing Non-Hospital Services (ARM 46.12.565)  Michelle Gillespie 444-3182 Reimbursement & coverage <i>Quality Assurance Division</i>  Carol Jorgensen 444-0190 Utilization review.	Skilled nursing services outside of a hospital which includes RN and LPN services.	-Ordered by a physician. -Prior authorized by Department. -Recipients must be under 21 years of age or receiving as part of home infusion therapy. -Respite care is not covered.	Department fee schedule.	Exempt, except for home infusion therapy
35. QDWI ( Qualified Disabled & Working Individual)  Wendy Olson 444-4189	Medicaid pays Medicare Part A premiums.			
36. QMB (Qualified Medicare Beneficiary)  Kathy Denme 444-4871	Medicaid pays Medicare premium, co-insurance and deductibles.		Up to Medicaid allowable charge or rate.	Established by service item.
37. Respiratory Therapy Services  Frank Malek 444-4068	Treatment in the home by a Licensed Respiratory Care Practitioner.	-Ordered by a physician. -Limited to individuals under 21 years of age/	Department fee schedule	Exempt.
38. School Based Services  Jeff Buska 444-4145	Medical care provided for children in a school setting.	Limited to individuals under age 21.	Department fee schedule.	Exempt.
39. Skilled and intermediate nursing services in long term care facilities.  <i>Senior &amp; Long Term Care</i>  Steve Blazina 444-4129	Meal services, medications, nursing and other health services, rehabilitative services, social services and activities programs.	-Ordered by a physician. -Certified by Department for level of care prior to admission/payment.	-Prospective per diem rate, composed of operating, direct nursing and property rates. -Prescription drugs & rehabilitation services (OT, PT, ST) are reimbursed on a fee schedule basis. Other ancillaries are reimbursed at provider acquisition cost.	Exempt.

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40. <b>Out of State Nursing Homes</b> (ARM 46.12.1251)  <i>Senior &amp; Long Term Care</i>  Kelly Williams 444-4147	Same as above.	Physician ordered prior approval by Department level of care certified.	Rate established by the State Medicaid agency in the state where facility is located.	Exempt.
41. <b>Swing Beds</b>  <i>Senior &amp; Long Term Care</i>  Kelly Williams 444-4147	LTC Services provided in swing beds when no NF beds are available in community & resident meets level of care.	No NF beds available in 25 mile radius of discharging hospital. Must be NF level of care.	Prior calendar year statewide average Medicaid rate for nursing facilities. (NF)	Exempt.
42. <b>Targeted Case Management</b> (ARM 46.12.1901-1940)  Shari Pettit (HPSD) 444-2574 Pregnant Women Special Health Needs  <i>Disability Determination Division</i> James Driggers 444-4090 Developmentally Delayed  <i>Addictive &amp; Mental Disorders Div.</i> Randy Poulsen 444-2706 Adults with Chronic Mental Illness, Severely Emotionally Disturbed Children.	Services designed to assist individuals in accessing needed medical, social, educational and vocational services. The four target groups covered are: -Pregnant women and infants through 1 year of life.  -Individuals 16 years of age and older with developmental delays.  -Individuals 18 years of age and older with severe mental illness. -Individuals up to 18 years of age with severe emotional disturbance.		Department fee schedule.	Exempt.

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44. <b>Transportation and per diem/Ambulance</b> (ARM 46.12.1001-1025)  Kathy Demme 444-4871 Reimbursement & Coverage  Prior Authorization: Mountain Pacific Quality Health Foundation  1-800-292-7114	Ambulance services, air transport, specialized non-emergency transportation services, commercial transportation, mileage and per diem.	-All non-emergency transportation must be prior authorized by MW/FMC. -Ambulance must be licensed under state law. -Ambulances are covered for emergency care and for non-emergency care when the patient is stretcher-bound and the ambulance is ordered by a physician. -Transportation is only covered to obtain medically necessary services from nearest provider. -Transportation is limited to the least expensive means suitable to meet the recipient's needs.	Department fee schedule.	\$1.00 per trip Specialized non-emergency.
45. <b>Indian Health Services</b> (Sec. 1905B, 1911A of the Social Security Act.)  Debra Stipcich 444-4834	Services provided by Indian Health Service Facilities.	Outpatient and Inpatient Services.	Fees set by HCFA annually per visit for outpatient per diem for inpatient.	Exempt.
46. <b>Health Insurance Premium Payment</b>  <i>Quality Assurance Div. - TPL</i>  1-800-457-1978	Group and Individual Health Policies	Health Plan must be determined to be cost effective by TPL prior to reimbursement.	Determined by TPL.	
47. <b>Medicare Buy-In</b>  <i>Quality Assurance Div - TPL</i>  Lynn Roberts 444-4552	Payment of Medicare premiums for QMB, SLMB, QDWI and SSI recipients.	Must be eligible for QMB, SLMB, QDWI or SSI related program.	Based on current year's Medicare premium rate as set by SSA.	

EXPERIMENTAL SERVICES ARE NOT COVERED BY MEDICAID

**PROVIDER INQUIRY OF MEDICAID/STATE MEDICAL ELIGIBILITY**

**Instructions:** Please complete the provider section of this form, sign and date, attach the applicable Statement of Remittance, and send to the client's welfare office. If you do not receive a response within ten days refer to your Medicaid Management Information System Provider Manual, Recipient Eligibility Section, for the county contact person. If you need more provider inquiry forms, please contact Consultec for reordering.

<b>Provider:</b> _____ Address: _____ City: _____	Provider ID Number: _____ Provider Phone Number: _____ Date of Inquiry: _____
<b>Patient:</b> Name: _____ ID #: _____ Date of Birth: _____ Date of Service: _____	<b>Parent or Guardian:</b> (if patient is a minor) Name: _____ ID #: _____ Address: _____ City: _____

**Information Being Requested:**

Please attach a copy of the Statement of Remittance. Highlight the line in question.

Signature of Requestor

Date

**County Response:****Dates of Eligibility:** \_\_\_\_\_

Signature of County Respondent

Title

Date

Distribution: Initial Request  
 Provider - Pink  
 County Office - Canary & White

County Response  
 County - Canary  
 Provider - White

